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Senate Hearing

Before the Committee on Appropriations

Oversight of Medicare Contractors' Payment Safeguard Activities

Fiscal Year 1990

101 *st* CONGRESS, FIRST SESSION

SPECIAL HEARING

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OVERSIGHT OF MEDICARE CONTRACTORS' PAYMENT SAFEGUARD ACTIVITIES

HEARING

BEFORE A

SUBCOMMITTEE OF THE

COMMITTEE ON APPROPRIATIONS

UNITED STATES SENATE

ONE HUNDREDTH FIRST CONGRESS

FIRST SESSION

SPECIAL HEARING

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OVERSIGHT OF MEDICARE CONTRACTORS' PAYMENT SAFEGUARD ACTIVITIES

TUESDAY, FEBRUARY 28, 1989

U.S. SENATE,
SUBCOMMITTEE ON LABOR, HEALTH AND HUMAN SERVICES, EDUCATION, AND RELATED AGENCIES,
COMMITTEE ON APPROPRIATIONS,
Washington, DC.

The subcommittee met at 9:30 a.m., in room SD–124, Dirksen Senate Office Building, Hon. Tom Harkin (chairman) presiding.

Present: Senators Harkin, Adams, and Specter.

NONDEPARTMENTAL WITNESSES

STATEMENTS OF:

MICHAEL ZIMMERMAN, DIRECTOR, MEDICARE/MEDICAID ISSUES, GENERAL ACCOUNTING OFFICE

RICHARD KUSSEROW, INSPECTOR GENERAL, DEPARTMENT OF HEALTH AND HUMAN SERVICES

ACCOMPANIED BY THOMAS G. DOWDAL, ASSISTANT DIRECTOR, GENERAL ACCOUNTING OFFICE

OPENING REMARKS OF SENATOR HARKIN

Senator HARKIN. The Senate Appropriations Subcommittee on Labor, Health and Human Services, and Education will come to order. I want to say good morning to all and welcome everybody to our subcommittee's kickoff hearing in the 101st Congress.

We are holding this hearing this morning as I said as a kickoff for the rest of the year and as a means of perhaps sending a message. We are facing some very tough budget problems this year. We have a great many unmet needs in the areas over which this subcommittee has jurisdiction in health, human services, and education.

President Bush has indicated several new initiatives that he has proposed in various areas that come under the jurisdiction of this subcommittee. However, the money to fund those programs is not included in that budget request.

SUBCOMMITTEE TO ENSURE FUNDS SPENT WISELY

However, the message we want to send is that this subcommittee intends to investigate carefully the expenditures of money from this subcommittee to make sure that the taxpayers dollars that are

spent, are spent wisely and well and that we get the most bang for the buck. Waste, fraud, and abuse wherever it occurs will be brought to public light and tightened down on by this subcommittee. We mean to make sure that every dollar, as I have said, is spent wisely, spent well, and will form the basis for our subsequent hearings as we proceed; whether it is through education, National Institutes of Health, human services, or in this case, health.

Today, we intend to explore inappropriate Medicare payments which waste the taxpayers' money. We want to explore the steps that need to be taken to eliminate or reduce fraud and waste from this program.

In my home State of Iowa, for example, farmers are always telling me about the great difficulty they have in obtaining loans and that they have to walk down a tightrope and through the eye of the needle as one farmer said to me to get funding from Farmers' Home Administration. Well, I just want to make sure that we subject requests for Medicare reimbursements to the same kind of scrutiny.

MEDICARE GROWTH

It is well known that Medicare outlays have increased about 12 percent a year in the years 1980 to 1988. This is true, in part, because the number of beneficiaries has grown and some of the growth is due to changes in substantive law which have increased the benefit levels. Parts of the growth with which I am particularly concerned are inappropriate payments made from the trust fund for services that were either medically unnecessary or inappropriate or payments that were made for providing levels of care, well in excess of what would be medically indicated, or payments that were made for services that were not provided.

A good thing about the Medicare program is that, when Medicare pays a doctor, a hospital, or a company which has provided a hospital bed or an oxygen tank to a beneficiary, a copy of that payment report goes to the citizen who received the services or the equipment. I want to makes it clear that citizens themselves can blow the whistle and report payments being made for services never received. In Iowa, I hear again and again from our seniors and others, stories of what many consider to be inappropriate payments.

EXAMPLES OF FRAUD

We are going to hear testimony today from the Department of Health and Human Services' Inspector General, who will document one well known case of fraud that cost the taxpayers over $35 million per year in wasted funds. We will hear from three Medicare contractors who will also tell us stories of the fraud they have uncovered through their audit activities.

For example, we will hear about, first a hospital that sought reimbursement for the costs of operating a private health club on two floors of the hospital. Second, physicians who billed for intermediate levels of care rather than for limited levels of care that would be more normally associated with routine followup visits. Third, billings for home visits when patients were residing in a

nursing home and, fourth, a hospital that billed for servicing Medicare patients on days when the patients were not even present at the hospital.

This committee does not have jurisdiction over the benefit levels of the Medicare program, and we do not want to impact legitimate payments. However, we do have jurisdiction over the budgets of the 64 contractors that administer the Medicare program.

So today's hearing will focus on aspects of those budgets which relate to protecting the Medicare trust fund from inappropriate and sometimes fraudulent expenditures of taxpayers dollars.

Our first witness this morning is Mr. Mike Zimmerman of the General Accounting Office. Mr. Zimmerman, I would like to ask you and each of the witnesses this morning to summarize your statements in 10 minutes or so. All of your statements, of course, will be printed in the record in their entirety.

Mr. Zimmerman, again welcome to the subcommittee. You and our staff and some of your people and I have had conversations about these situations and problems. I want to compliment you for your diligent efforts and ask you to please proceed, identify the two people who are with you.

SUMMARY STATEMENT

Mr. ZIMMERMAN. Let me begin first, Mr. Chairman, by making reference to Mr. Tom Dowdal who is on my left. He is the Assistant Director in charge of Medicare work and Mr. Kusserow who is the Inspector General, Department of Health and Human Services.

We are pleased to be here today to discuss the payment safeguard functions performed by Medicare's claim processing contractors. As you requested, we will first review the history of Medicare's cost growth and then we will discuss trends in contractor costs and the importance of contractor payment safeguard activities in assuring the integrity of Medicare's trust funds. Medicare is the fourth largest category of Federal expenditures after defense, Social Security, and interest payments on the national debt. Throughout Medicare's history, benefit costs have grown faster than both the general inflation rate and the gross national product, just as health expenses in general have.

Benefit costs increased from $34.6 billion in 1980 to $87.5 billion in 1988, an average annual increase of about 12½ percent. I might add that the program is expected to cost $109 billion in fiscal year 1990. Of this amount, $1.9 billion or about 1.7 percent represents administrative costs including those incurred by the Health Care Financing Administration, the Federal agency responsible for Medicare.

One reason for Medicare's high growth rate has been an increasing number of beneficiaries. Since 1980 the number of beneficiaries has increased by about 5 million to 33 million. Another reason has been that, on the average, each beneficiary has received more services and more expensive types of services, in part, because of the availability of new technology.

The amount Medicare contractors are paid for claims processing has decreased—falling from $1.73 per claim in 1984 to an estimated $1.34 per claim in 1989, an average annual decrease of 4 percent.

MEDICARE CONTRACTOR FUNCTIONS

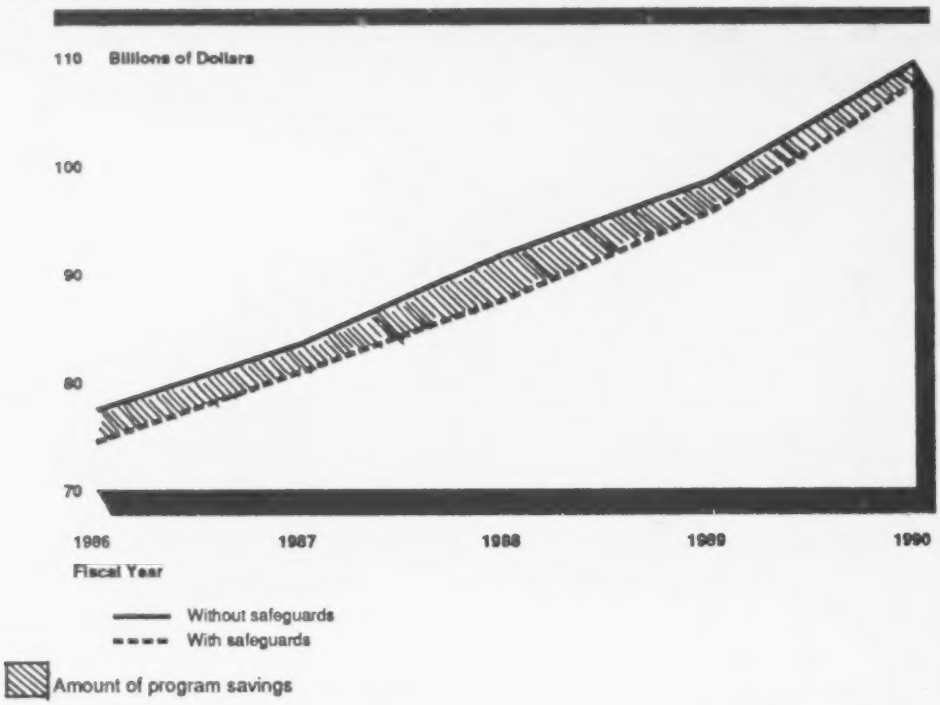
Carriers and intermediaries perform two functions to assure the accuracy of Medicare payments, claims processing and payment safeguard reviews. Claims processing involved more than just receiving, processing, and paying claims. A very important part of this function is assuring the accuracy of the payments. This involves efforts to verify that services are covered, that charges are reasonable, that the claim is not a duplicate, and that numerous other payment criteria have been met. Thus, the claims processing function can result in the outright denial of claims or in identifying claims that need further review through payment safeguard activities.

For example, during fiscal year 1988 carriers denied payment in whole or in part on about 65 million claims. These denials prevented $7.3 billion in erroneous Medicare payments. Also, in enforcing Medicare's reasonable charge criteria, carriers reduced submitted charges by about $13 billion in fiscal year 1988.

CONTRACTOR SAFEGUARD ACTIVITIES

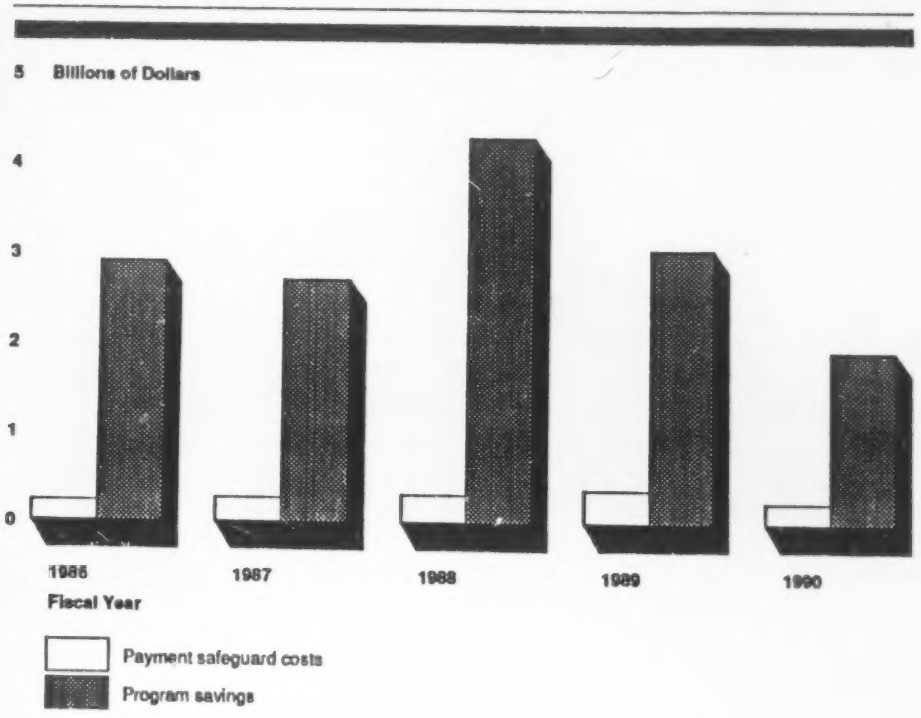
Turning now to contractor safeguard activities, the chart that I have that is nearest to you shows Medicare savings from payment safeguards. The top line indicates what the program costs would have been without payment safeguards, the dashed line represents the program costs with safeguards, and the shaded area between the lines, the amount of the savings. During the past 4 years, payment safeguards have resulted in average annual savings of about $3.25 billion.

MEDICARE SAVINGS FROM PAYMENT SAFEGUARDS



The next chart I have shows the return on investment from payment safeguards. Starting with fiscal year 1986, the chart compares for each year the program savings achieved with payment safeguard costs for that year. During the past 4 years, safeguards have returned on the average $11 for every $1 spent. As you can see from the chart, estimated program savings and safeguard costs for fiscal year 1990 are significantly less and I will touch on this later in my statement.

RETURN ON INVESTMENT FROM PAYMENT SAFEGUARDS



TYPES OF SAFEGUARD ACTIVITIES

Payment safeguards include three types of activities. First, the contractor performs reviews of submitted claims to determine if the services furnished were medically necessary and appropriate. The contractors look for such things as overprovision of services and furnishing of services not necessary for the treatment of the patient's condition. In fiscal year 1988 these review activities saved Medicare $866 million.

The second major payment safeguard activity is intermediary audits of the cost reports for providers that are reimbursed on a cost basis such as home health agencies. In fiscal year 1988, auditing and settlement activities resulted in program savings of about $2 billion.

The third safeguard activity is assuring that other insurers whose coverage is primary to Medicare pay claims before the Medicare program does. This safeguard is called a Medicare secondary payer or MSP program. In fiscal year 1988 MSP activities saved Medicare $1.4 billion.

In addition to these three payment safeguard activities, carriers and intermediaries are important sources of referrals to the Inspector General's Office in its efforts to identify and prosecute instances of fraud and abuse against the Medicare program.

In summary, without the combined control mechanisms provided by the claims processing and payment safeguard functions, Medi-

care costs in fiscal year 1988 would have been at least $20 billion higher. To continue to be effective, both of these functions need to be adequately funded. Underfunding claims processing can result in identifying fewer claims for review and underfunding payment safeguards can result in inadequate review of claims identified during processing.

MEDICARE FISCAL YEAR 1990 BUDGET REQUEST

Turning now to the fiscal year 1990 budget request for Medicare. It represents an increase of $78.6 million or 5.4 percent above fiscal year 1989 appropriations. While this would appear to be a reasonable increase, a closer analysis indicates otherwise.

The major increase in funding is for activities related to the Medicare Catastrophic Health Insurance Program drug benefit, a $128 million increase. In other major areas the budget request actually represents a decrease in funding.

REDUCTION IN PAYMENT SAFEGUARD FUNDING

For example, payment safeguard funding would be reduced by almost one-half from an overall average expenditure of 75 cents per claim to 41 cents per claim. This reduction in funding for payment safeguard activities could have a significant effect on Medicare program costs. HCFA estimates that fiscal year 1989 expenditures of $363 million will produce $3 billion in savings, a cost-savings ratio of $1 to $8. The fiscal year 1990 budget request for $229 million is expected to result in savings of $1.9 billion and this request is $134 million less than appropriated in fiscal year 1989.

Applying HCFA's 1 to 8 estimated cost to savings ratio for fiscal year 1989 to fiscal year 1990 indicates that the $134 million reduction in program safeguard funding could cost Medicare about $1.1 billion in erroneous benefit payments. Reducing payment safeguard funding appears to us to be penny wise and pound foolish.

We have supported adequate funding for claims processing and for payment safeguard activities for many years and we have also recommended actions to improve the efficiency of claims processing and the effectiveness of these safeguards and my prepared statement provides some examples.

PREPARED STATEMENT

In summary, we do not believe that all carriers and intermediary functions are performed as efficiently or as effectively as possible. However, reducing the amount these contractors receive for payment safeguard activities is not, in our opinion, the way to improve operations. Such a reduction could result in a significant increase in erroneous benefit payments and increase the risk of fraud and abuse. This concludes my prepared statement, Mr. Chairman. We would be glad to answer any questions you have.

[The statement follows:]

STATEMENT OF MICHAEL ZIMMERMAN

We are pleased to be here today to discuss the payment safeguard functions performed by Medicare's claims processing contractors--called intermediaries for part A hospital insurance and carriers for part B supplementary medical insurance.[1] As you requested, we will first review the history of Medicare's cost growth. Then we will discuss trends in contractor costs and the importance of contractor payment safeguard activities in assuring the integrity of the Medicare trust funds. Payments to contractors cover primarily four functions: provider and beneficiary services; claims processing; payment safeguards and investments to improve contractor systems.

Let me say at the outset that we believe that reducing the amount Medicare's claims processing contractors receive for payment safeguard activities, by $134 million as proposed by the budget request, would not be cost effective. In fiscal year 1988 these activities saved $4.3 billion on an investment of $305 million. The administrative savings achieved by reducing funding for payment safeguards could be greatly exceeded by the increase in erroneous benefit payments.

GROWTH OF THE MEDICARE PROGRAM

Medicare is the fourth largest category of federal expenditures after defense, social security, and interest

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[1]Intermediaries and carriers are insurance companies that contract with Medicare to process and pay claims for Medicare benefits. These contractors are responsible for assuring that only claims for covered, medically necessary services are paid and that the amount paid is in accordance with Medicare rules. They are also the main channel for communication with beneficiaries and providers about matters relating to claims and coverage of services.

payments on the national debt. During fiscal year 1990, Medicare is expected to provide health coverage for over 33 million aged and disabled persons at a total cost of $109 billion. Of this amount, $1.9 billion or 1.7 percent represents administrative costs, including those incurred by the Health Care Financing Administration (HCFA) and those paid to the Medicare contractors for processing about 560 million claims.

Throughout Medicare's history, benefit costs have grown faster than both the general inflation rate and the gross national product, just as health expenses in general have. Benefit costs increased from $34.6 billion in 1980 to $87.5 billion in 1988, an average annual increase of about 12.4 percent. One reason for the high growth rate has been an increasing number of beneficiaries. During the period 1980 through 1988, Medicare beneficiaries increased about 14 percent, from 28.1 million to 32 million. Another reason has been that, on average, each beneficiary has received more services and more expensive types of services in part because of the availability of new technology. When viewed from the perspective of average cost per beneficiary, however, Medicare cost-growth rates have not been as high as the overall figures indicate. The average cost per beneficiary increased from $1,247 in fiscal year 1980 to $2,754 in fiscal year 1988, an average annual increase of about 10.5 percent.

Turning now to the costs for administering the Medicare program, from 1984 through 1989 the total amount paid to the Medicare contractors increased from $862 million to about $1.5 billion, an average annual increase of 11.5 percent. However, the number of claims processed increased even more rapidly. Thus, on a cost-per-claim-processed basis, administrative costs actually decreased during that period--dropping from $3.08 in

1984 to an estimated $2.98 in 1989, an average annual decrease of about 0.3 percent.

The amount Medicare contractors are paid just for the claims processing function has decreased more dramatically--falling from $1.73 per claim in 1984 to an estimated $1.34 per claim in 1989, an average annual decrease of about 4 percent. Put another way, the claims volume increased 72 percent during this period--from 280 to 490 million claims, but the amount that Medicare contractors were paid to process these claims increased by only 36 percent--from $484 to $657 million.

IMPORTANCE OF PAYMENT SAFEGUARD ACTIVITIES

Medicare is a complex program with numerous rules about the types of services covered, the conditions under which the services qualify for payment, and the method for determining the payment amount for covered services. These rules are designed to assure that (1) only medically necessary and appropriate care is provided to beneficiaries, (2) the amount paid for such care is reasonable, and (3) the program is protected from fraud and abuse. Most of the money carriers and intermediaries receive from Medicare is for enforcing these rules.

Carriers and intermediaries perform two functions to assure the accuracy of Medicare payments--claims processing and payment safeguard reviews. The claims processing activity involves more than just receiving, processing, and paying claims. A very important part of this function is assuring the accuracy of payments. This involves a myriad of checks--both automated and manual--to verify that services are covered, that charges are reasonable, that the claim is not a duplicate, and that numerous other payment criteria have been met. Thus, the claims processing function can result in the outright denial of claims

or in identifying claims that need further review through payment safeguard activities. For example, during fiscal year 1988, carriers denied payment in whole or in part on 64.7 million claims (17 percent of all claims). These denials prevented $7.3 billion in erroneous payments. By enforcing Medicare's reasonable charge criteria, carriers also reduced submitted charges by $12.9 billion in fiscal year 1988.

Contractor payment safeguard activities complement the normal claims processing activities by providing an additional means to assure that Medicare payments are appropriate. Payment safeguards include three types of activities. First, the contractors perform medical and utilization review of submitted claims to determine if the services furnished were medically necessary and appropriate.[2] The contractors look for such things as overprovision of services and furnishing of services not necessary for the treatment of the patient's condition. In fiscal year 1988, carrier and intermediary medical and utilization review activities saved Medicare $866 million.

The second major payment safeguard activity is intermediary audits of the cost reports for providers that are reimbursed on a cost basis, such as home health agencies and for certain hospitals' services paid on a cost basis. In fiscal year 1988, intermediary auditing and settlement activities resulted in program savings of $2 billion.

The third safeguard activity is assuring that other insurers, whose coverage is primary to Medicare, pay claims before the Medicare program does. This safeguard is called the

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[2]Intermediaries do not review inpatient hospital claims for medical necessity or appropriateness. This function is performed by peer review organizations, commonly referred to as PROs, which contract with Medicare specifically for this function.

Medicare Secondary Payer (MSP) program. In fiscal year 1988, carrier and intermediary MSP activities saved Medicare $1.4 billion.

In addition to these three payment safeguard activities, carriers and intermediaries are important sources of referrals to and information for the HHS Inspector General's Office in its efforts to identify and prosecute instances of fraud and abuse against the Medicare program.

In summary, without the combined control mechanisms provided by the claims processing and payment safeguard functions, Medicare costs in fiscal year 1988 would have been at least $20 billion higher. To continue to be effective, both these functions need to be adequately funded. Underfunding claims processing can result in identifying fewer claims for review, and underfunding payment safeguards can result in inadequate review of claims identified during processing.

MEDICARE CONTRACTOR BUDGET REQUEST INADEQUATE

The fiscal year 1990 budget request for Medicare contractors represents an increase of $78.6 million or 5.4 percent above the fiscal year 1989 appropriation. While this would appear to be a reasonable increase, a closer analysis indicates otherwise. The major increase in funding is for activities related to the Medicare catastrophic health insurance program's drug benefit (a $128-million increase). In other major areas, the budget request actually represents a decrease in funding. Claims are expected to grow by 14 percent, but the budget request for the claims processing function represents only a 2-percent increase. On a cost-per-claim basis, this represents a 4-percent decrease. Payment safeguard funding would

be reduced by almost one-half, from an overall average expenditure of 75 cents per claim to 41 cents per claim.

This reduction in funding for payment safeguard activities could have a significant affect on Medicare program costs. In fiscal year 1988, payment safeguard funding was $305 million and resulted in savings of $4.3 billion--for every $1 spent, $14 was saved. HCFA estimates that fiscal year 1989 expenditures of $363 million will produce $3 billion in savings, a cost to savings ratio of $1 to $8. The fiscal year 1990 budget request for $229 million is expected to result in savings of $1.9 billion or a cost to savings ratio of $1 to $12. This request is $134 million less than appropriated for fiscal year 1989. Applying HCFA's $1 to $8 estimated cost to savings ratio for fiscal year 1989 to fiscal year 1990 indicates that the $134 million reduction in program safeguard funding could cost Medicare about $1.1 billion in erroneous benefit payments. Reducing payment safeguard funding appears to be penny-wise and pound-foolish.

PAYMENT SAFEGUARD ACTIVITIES COULD BE IMPROVED

We have supported adequate funding for claims processing and payment safeguards for many years. We have also recommended actions to improve the efficiency of claims processing and the effectiveness of these safeguards. For example, in November 1988,[3] we reported that Medicare was still paying many claims that other insurers should pay because they do not have adequate incentives to comply with Medicare's secondary payer provisions. We recommended that the Congress amend the Social Security Act to provide for Medicare to collect from insurers twice the amount

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[3]Medicare: Incentives Needed to Assure Private Insurers Pay Before Medicare, GAO/HRD-89-19, Nov. 29, 1988.

owed when they do not properly treat Medicare as the secondary payer. We also recommended that HCFA improve its evaluation of contractors' MSP-related performance.

In another November 1988 report,[4] we pointed out that, while improving Medicare's methods of determining the allowable amount for physician and other services is important, payment reforms in themselves would not control overall costs because they would not control the quantity of services furnished. We suggested that benchmarks should be developed for the extent of services considered medically necessary to treat specific illnesses and justification should be required before paying for services exceeding the benchmarks. Carriers could use these benchmarks to improve the effectiveness of their utilization-review activities.

After our last major review of contractor operations, we concluded that HCFA could better use its contract authority to improve contractor performance and to remove from the program those contractors who consistently perform poorly.[5] We made several recommendations along these lines.

As I indicated earlier, we do not believe that all carrier and intermediary functions are performed as efficiently or as effectively as possible. However, reducing the amount these contractors receive for payment safeguard activities, as proposed by the budget request, is not, in our opinion, the way to improve operations. Such a reduction could result in a significant increase in erroneous benefit payments and increase the risk of fraud and abuse.

This concludes my prepared statement. I will be happy to answer any questions you may have.

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[4]Transition Series: Health and Human Services Issues, GAO/OCG-89-10TR, Nov. 1988.

[5]Medicare: Existing Contract Authority Can Provide for Effective Program Administration, GAO/HRD-86-48, Apr. 22, 1986.

REMARKS OF SENATOR BROCK ADAMS

Senator HARKIN. Thank you very much. I have a series of questions concerning the charts and some of your testimony. I thought that before we do that, I would go ahead and have Mr. Kusserow testify. Before that I would like to recognize my colleague from Washington, Senator Adams, for any opening statement or comments you might have.

Senator ADAMS. I do not have an opening statement, Mr. Chairman. It is a pleasure to join you as a member of this subcommittee and I look forward to working with you and I am going to have to leave to go to another subcommittee meeting soon, but I appreciate the opportunity to be here and I look forward to working with you. Thank you very much, Mr. Zimmerman, for your testimony.

Senator HARKIN. Thank you, Senator.

STATEMENT OF RICHARD KUSSEROW

Richard T. Kusserow, Inspector General from the Department of Health and Human Services. Your statement will be made a part of the record. Go ahead and please proceed.

Mr. KUSSEROW. I will go ahead and speak. On behalf of the Department of Health and Human Services, now as the Office of the Inspector General. I will take advantage of the offer you made and submit my testimony for the record in its entirety and then maybe highlight some points which I think are worthy of spending a little time on and also affording a greater opportunity for questioning.

The Health Care Financing Administration has over 100 contracts with the eight different entities that do a lot of things for financing of Medicare. They look at prepayment screens, make sure that patients are eligible, services are covered. They want to be sure that Medicare when it is a secondary payer is, in fact, paying secondarily and not as a first payer. They audit the providers. They engage in utilization of medical review. They do provide beneficiary and provider services and also they look for fraud and abuse such as what is the subject of much of your hearing today.

The Health Care Financing Administration, as Mr. Zimmerman pointed out, does report a great return on the dollar invested in this arena. Seven to one for return on audits and medical and utilization reviews and even greater $21 to $1 return on other types of payer activities. The thing that you will hear from the Health Care Financing Administration later in the hearing is the fact that there is an enormous range of the types of performance by the carriers and intermediaries, that some do far better than the average and some do far worse than the average.

SAFEGUARD ACTIVITIES A SOURCE OF REFERRALS

We have a very strong interest in the safeguard activities. In fact, it is, as Mr. Zimmerman pointed out, it is a major source of cases for us to investigate to make sure that people are not engaged in fraudulent and abusive practices in Medicare.

We get about 400 referrals a year from carriers alone. About 6 percent of those referrals result in successful actions, convictions,

or sanctioning. That averages out, as far as we are concerned, to about 9 percent of our conviction ratio in this health care arena.

One of the reasons why the percentage of cases that lead to successful outcomes is so low, however, is that we have a serious definitional problem. For example, one carrier might submit a case involving a physician with 16 different questionable billings and refer that as a single case, whereas another carrier might refer to that as 16 different cases.

If we just look at the number of referrals that result in successful actions and measure the contractors on that alone, it would not be fair to them because they, in fact, have another very important role that they have as far as we are concerned, that is, they support us when we, in fact, engage in investigation. They support us in gathering data and evidence that would lead to bringing people to the bar of justice.

As we look across the contractor landscape we see that when contractors are good, they are very good. When they are not, they are not. About 10 percent of the contractors are very good, that is, they submit cases that are well developed. There is very little lost in the way of going through those allegations and referrals, they usually have a very high success outcome. We have another two-thirds that we would say are in the average arena. We get maybe two, maybe three well-developed referrals annually. They, in fact, reach the average of about 6 percent successful actions on the number of referrals they submit and then we have about one-quarter of the carriers that are very poor. They do not really refer very many cases that are actionable. They are not very cooperative when we conduct investigations and in some cases we have even had to go so far as to subpoena records out of them in order for us to make sure that we rout out the bad folks.

One of the things that we are doing ourselves to help in this arena is we have engaged in a nationwide effort to work with contractors, setting up training programs, trying to help them understand what it would take in the form of referral to lead to a successful outcome and we are making some good progress along that line.

PROBLEMS IN SEAT LIFT CHAIR AREA

As you pointed out in your opening statement, Mr. Chairman, we have in the arena of durable medical equipment, particularly in the seat lift chair area, encountered some real problems. We have, for example, just received a short time ago an indictment from a Federal grand jury on owners and operators of a durable medical equipment company that specialized in seat lift chairs.

Basically the company's marketing strategy was going after Medicare patients. They even went so far as to purchase telephone lists of persons over 65. Then they would have sales representatives from the company call on beneficiaries and tell them that seat lift chairs would be supplied in their homes and it would be at no cost. They would obtain the beneficiary's attending physician's name from the beneficiary. They would then go and prepare the authorization documents and put it in front of the physician and get them to sign off on it. They oftentimes listed the equipment which the

beneficiary really had not requested and had fed to the physician greatly exaggerated diagnostic problems to justify having this kind of equipment.

Sometimes they would intimidate the attending physicians to sign the contrived authorizations using threat of loss of the patient, perhaps even a lawsuit, because of the fact that it already had contact with the patient and the patient had expressed interest in the device. The provider even formed a mobile diagnostic care company and hired certain physicians to sign the authorizations for beneficiaries whose doctors refused to do so. Some beneficiaries never received the chair and we are finding that as a pattern across a number of different devices where we are coming up with a nationwide study showing that as many as 9 or 10 percent of beneficiaries do not see certain types of devices that have been paid for by Medicare.

In this one instance I am referring to we found over $400,000 in very questionable and false claims for this one company alone. It would be remiss on my part if I did not point out that this investigation would not have reached the grand jury, would not have reached the indictment phase had it not been for the contractor that assisted us in developing the evidence and making the claim. We have also done additional work in seat lift chairs around the country.

One of the things we have also done is a nationwide study that we are releasing to the committee today and for the record a study that we did on Medicare coverage of seat lift chairs which enumerate basically what we are finding in this particular area of durable medical equipment sphere and perhaps that would be of use to the committee in evaluating the overall problem nationwide.

We are also in the process of doing a major audit in the area of seat lift chairs and if you would like, Mr. Chairman, at the conclusion of that audit we will make that also available to the committee. It will enumerate a number of other types of abuses in the seat left chair arena.

Overall, in looking at the seat lift chairs as just one single medical device that is being marketed primarily to Medicare beneficiaries, we can see that by tightening up some of the controls in this system, with the contractors, we could save somewhere between $30 and $60 million a year just in this one area.

OTHER WASTE AND ABUSE CASES

From your home State, Mr. Chairman, Blue Cross and Blue Shield of Iowa brought to our attention a case where a provider was billing Medicare for home health services while patients were actually in the hospital and, as a result of that, we have turned that into a criminal investigation on that agency and that could very well lead to a successful prosecution.

In another State, the carrier estimated that a plastic surgeon falsely billed over $1.5 million to Medicare over a 2-year period. The surgeon who only treated hospital and nursing home patients with skin ulcers upgraded the billing codes for his services and exaggerated the number of lesions he treated. We successfully prosecuted him. He was sentenced to 6 months in a halfway house and

$10,000 fine and also placed on 5 years probation as opposed to being kicked out of Medicare and Medicaid.

We also, as you know, Mr. Chairman, are involved in looking at other medical devices such as the so-called TENS devices, the transcutaneous nerve stimulation devices. There again, we have another nationwide study. We are looking at that and we are beginning to see certain common problems that really need to be addressed at the contractor level.

Among the problems that we are encountering is that the heavy emphasis on claims processing, which is essential to the payment process for Medicare, has meant that there has not been as much emphasis on payment safeguards as we would like to see. Again, Mr. Chairman, you will hear later on from the Health Care Financing Administration the range of performance here is enormous.

CONTRACTOR PROGRAM INTEGRITY ACTIVITIES

We also have in our 1988 study of contractor program integrity activities found that carriers oftentimes fail to identify substantial fraud and abuse violations. We also see that they fail to develop these violations in accordance with established law and abuse procedures, they are not being followed properly. We see that oftentimes they will fail to refer cases to the Office of Inspector General as is required and we also found that during a period of time when funding for the safeguards activities was deemed adequate, but there still seems to be a lack of commitment to this particular arena.

We also found that even when the contractor had emphasis on claims processing we were concerned that there was an increase in the number of appeals denied in these cases which meant that the ultimate savings figures were greatly reduced over that which was claimed. We also saw that this leads to a larger problem in that we may not really have an accurate picture as to what the return rate is on the contractors and in the performance of their audit and review activities.

OTHER STUDIES UNDERWAY

We will be proceeding this year to do a number of studies to actually see if we can refine the numbers that Mr. Zimmerman provided you in these charts and get behind those numbers and find out what the actual return rate is.

We are, in fact, engaged now on all three fronts to look at the audit and other postpayment and prepayment review process and see if we can give you accurate information as to what the return rate is; as well as best practices and poor practices around the country so we will have a better understanding of why it is that there is such a wide range of performance.

We have some recommendations that could arise from all of these studies that we could share with you. One of the things that we find as a modus operandi in these types of durable medical devices cases that are oftentimes being used to abuse Medicare has been that physicians would routinely sign off on forms prepared by the suppliers. That caused a great deal of concern for us. We think

that is not the way in which we should determine medical diagnosis and prescription. We find that there should be direct communication with the patient on how useful and effective these devices are. We find it is pretty much lacking in that arena.

One of the things that concerns us is the fact that suppliers are involved in actually handling the forms and making the arrangements for payment. We think that is wrong. That leads us to make some recommendations.

One of the things is that we should look to the physician to have a greater responsibility in the prescribing of these devices and the prescription should come on the physicians own stationery and should relate to the medical history of the patient. In that way we feel that the physician is more vested in the patient's interest than what we have in some cases now.

Also, quite frankly, it would be our opinion that where a physician were to prescribe a device without having really reviewed the necessity for the patient or do it as a courtesy or whatever for a supplier, that, in fact, that a liability to the physician should accrue and that the Government should not stand a loss when we uncover something like that, that the physician should pay for the loss and perhaps with penalties.

We also are very eager to see a rigorous enforcement of the new rules set forth by the Health Care Financing Administration last month on applying the inherent reasonableness provisions, and there it really says that we are going to come in with the lowest charge level for these devices.

One of the things that we find, Mr. Chairman, is that a device such as the seat lift chair that you have here before you today, can range enormously in what is being charged against Medicare. Essentially the same kind of a chair can cost $800, could cost $1,000, $1,200, $1,600 or more. So there really should be what is the lowest available charges in the neighborhood.

We also feel that steps must be taken to have the patient involved in the decisionmaking, much more clearly than what is now and not just have the supplier be their spokesman but actually that they communicate directly to the people who are paying the bill, namely Medicare and the contractors.

REMARKS OF SENATOR ARLEN SPECTER

Senator HARKIN. Mr. Kusserow, Senator Specter has another subject that he has to move to. I know he is very interested in this area. He has expressed that to me. He is the ranking member of the subcommittee and I would just like to recognize him because I know he has a number of other subcommittee meetings today and I would like to recognize the Senator.

Senator SPECTER. Thank you, Mr. Chairman. I am reluctant to interrupt you but I would like to do so for just a moment to express my regrets at my late arrival from the Defense Subcommittee which is also in session. I am due at the Intelligence Committee and we have got the Deputy Director of the CIA on a hearing that started a few moments ago.

I am very much concerned about the subject matter of today's hearing and I hope to return before it is over, but that is uncertain

and I will be following it very closely and I want to express my regrets publicly at being unable to hear all of the testimony. Thank you very much, Mr. Chairman.

Senator HARKIN. Thank you, Senator Specter. Mr. Kusserow, go ahead and see if we can wrap up here.

CONCERNS ABOUT PAYMENT SAFEGUARD ACTIVITIES

Mr. KUSSEROW. I will wrap up very quickly, Mr. Chairman. One of the concerns that I have and I share this again with Mr. Zimmerman, is that when decisions are made as to effecting economies, we want to be sure they are not false economies. I am concerned that safeguards do not have a high enough priority with our Department in terms of funding. I am concerned that we have a system of rating performance of contractors and fraud and abuse and safeguard activities are not a more important part of that process.

I believe that we must find a way in which we can take some of the aberrations out of the system where, indeed, if you find there is a factor akin between good performers in the safeguard arena and poor performers that action is taken to take those poor performers and bring them up to a much higher level so we get a better return.

Both GAO and the Office of Inspector General are concerned about the inefficiencies that are in the safeguard arena. Pending this particular aspect of the contractor budget, to the degree that it is, it seems to me that that is not putting the proper weight on watching out for the taxpayers' dollars and watching out for the beneficiaries' interest. And anything that we can do to raise the conscious level of the HCFA and the Department to putting safeguards as a higher priority, I think would be very useful for all parties concerned.

PREPARED STATEMENT

I believe that somewhere along the line, the inspector general needs to be brought into some of the policymaking as to what kind of weighting we should have for safeguards, much more so than he has been heretofore. I also think that when we do encounter problems, when we find weaknesses in the system, we find that there is a new device being marketed and we find that it is being abused, that once it has been identified and once we find what actions we can take to correct that system, then I think we have to have a means by which we communicate that to all of the contractors and expect to act upon it. The one thing we have learned is that when Congress put new controls in the systems when they find abuses it can have a enormous benefit in terms of return on the tax dollar. I am afraid that is not being done to the degree that I would say should be considered satisfactory. At that point, Mr. Chairman, let me stand by also to answer any questions you and the committee might have.

[The statement follows:]

STATEMENT OF RICHARD P. KUSSEROW

GOOD MORNING, I AM RICHARD P. KUSSEROW, INSPECTOR GENERAL OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES. LET ME THANK YOU FOR THE OPPORTUNITY TO TESTIFY THIS MORNING ON MEDICARE CONTRACTORS. AS REQUESTED, WE ARE PROVIDING THE SUBCOMMITTEE WITH SOME OF OUR INSIGHTS REGARDING HOW EFFECTIVE MEDICARE CONTRACTORS ARE IN PERFORMING THEIR PAYMENT SAFEGUARD FUNCTION IN THESE TIMES OF RISING DOLLAR HEALTH CARE EXPENDITURES.

INTRODUCTION

IN 1989, THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, WHICH ADMINISTERS THE MEDICARE PROGRAM, WILL SPEND APPROXIMATELY $100 BILLION FOR THE HEALTH CARE OF MORE THAN 33 MILLION BENEFICIARIES. TO PAY FOR THESE SERVICES, THE HEALTH CARE FINANCING ADMINISTRATION (HCFA), WHICH IS RESPONSIBLE FOR ADMINISTERING THE PROGRAM, CONTRACTS WITH A NUMBER OF PRIVATE INSURANCE COMPANIES TO HANDLE THE CLAIMS AND DISBURSEMENT OF FUNDS. CONTRACTORS WHO MAKE THESE PAYMENTS FOR MEDICARE PART A SERVICES, WHICH INCLUDE INPATIENT HOSPITAL, HOME HEALTH, AND SKILLED NURSING SERVICES, ARE CALLED FISCAL INTERMEDIARIES. CONTRACTORS WHO MAKE PAYMENTS FOR MEDICARE PART B SERVICES, WHICH INCLUDE PHYSICIAN, OUTPATIENT SURGERY AND TESTING SERVICES, ARE KNOWN AS CARRIERS. CURRENTLY, THERE ARE ABOUT 88 SUCH CONTRACTORS. EACH CONTRACTOR HAS RESPONSIBILITY FOR PAYMENT OF CLAIMS IN A DESIGNATED GEOGRAPHIC AREA. THE HCFA PROVIDES DIRECTION TO THE CONTRACTORS ON PAYMENT MATTERS AND IS RESPONSIBLE FOR ASSURING THAT THEY ADHERE TO PROGRAM POLICIES AND PROCEDURES FOR TIMELY AND PROPER PAYMENTS AND PAYMENT SAFEGUARD ACTIVITIES.

CONTRACTOR RESPONSIBILITIES

THESE PRIVATE SECTOR ORGANIZATIONS, SUCH AS BLUE CROSS AND BLUE SHIELD PLANS AND COMMERCIAL INSURANCE COMPANIES, UNDERTAKE A NUMBER OF SPECIFIC AND GREATLY NEEDED FUNCTIONS IN THEIR ROLE AS MEDICARE CONTRACTORS TO INSURE THE ACCURACY OF MEDICARE PAYMENTS. AS MEDICARE CONTRACTORS, THESE ORGANIZATIONS REVIEW CLAIMS, CONDUCT POST-PAYMENT UTILIZATION REVIEWS, APPLY FRONT-END COMPUTER SCREENS TO IDENTIFY NON-COVERED SERVICES AND FRAUDULENT CLAIMS, GATHER DATA FOR INVESTIGATIONS AND AUDITS AND IDENTIFY CLAIMS WHICH SHOULD BE PAID BY OTHER INSURERS. IN 1988, CONTRACTORS HANDLED APPROXIMATELY 450 MILLION CLAIMS. GIVEN THE CONTINUING RISE IN THE NUMBER AND COST OF MEDICARE CLAIMS, IT IS IMPERATIVE THAT THE CONTRACTORS REVIEW CLAIMS WITH ACCURACY AND INSURE THAT PAYMENTS ARE MADE ONLY FOR MEDICALLY NECESSARY, HIGH QUALITY CARE WHICH IS COVERED BY THE MEDICARE PROGRAM. FURTHER, IN CASES IN WHICH MEDICARE'S LIABILITY IS SECONDARY TO OTHER HEALTH COVERAGE, THAT THESE CLAIMS ARE IDENTIFIED AND PROPERLY RESOLVED.

PAYMENT SAFEGUARDS

THE SOCIAL SECURITY ACT REQUIRES HCFA TO DEVELOP SYSTEMS TO PROTECT MEDICARE FROM THE UNNECESSARY UTILIZATION OF SERVICES FURNISHED BY PROVIDERS AND SUPPLIERS. HCFA HAS DEVELOPED PROCEDURES WHICH REQUIRE CARRIERS TO APPLY A COMBINATION OF PREPAYMENT AND POST-PAYMENT REVIEWS TO DETER UNNECESSARY UTILIZATIONS. THE CONTRACTORS ARE ALSO REQUIRED TO PROMPTLY DETECT AND ACT ON POTENTIALLY FRAUDULENT OR ABUSIVE ACTIVITY.

WHEN A CONTRACTOR RECEIVES A CLAIM, THE INFORMATION ON THE CLAIM FORM IS ENTERED INTO THE CONTRACTOR'S SYSTEM. THE CLAIM IS THEN SUBJECTED TO A COMPLEX SET OF PREPAYMENT SCREENS AND EDITS. THE AUTOMATED SCREENING PROCESS:

- VERIFIES ELIGIBILITY OF THE BENEFICIARY;
- INSURES THAT THE PROVIDER OR PHYSICIAN IS ELIGIBLE TO RECEIVE MEDICARE REIMBURSEMENT;
- INSURES THAT THE SERVICE IS A COVERED SERVICE UNDER MEDICARE;
- DETERMINES IF THE SERVICE SHOULD BE PAID BY ANOTHER INSURER;
- DETERMINES, BASED ON A REVIEW OF THE BENEFICIARY'S HISTORY, WHETHER THE SERVICE IS MEDICALLY NECESSARY;
- INSURES THAT SPECIAL MEDICARE DOCUMENTATION REQUIREMENTS ARE MET; AND
- PROTECTS AGAINST FRAUD BY IDENTIFYING ONCE IN A LIFETIME PROCEDURES (E.G., REMOVAL OF GALL BLADDER) WHICH WERE PREVIOUSLY PERFORMED ON THE BENEFICIARY.

FROM A FRAUD AND ABUSE PERSPECTIVE, AN EVEN MORE IMPORTANT ACTIVITY IS CONDUCTED AFTER THE INDIVIDUAL CLAIM IS PAID. A POST-PAYMENT UTILIZATION REVIEW ACTIVITY IS REQUIRED TO BE CONDUCTED BY THE CONTRACTORS IN ORDER TO IDENTIFY PROBLEMS THAT CANNOT BE DETECTED BY A REVIEW OF INDIVIDUAL CLAIMS. SPECIFICALLY, THE CONTRACTORS ARE REQUIRED TO AGGREGATE THEIR CLAIMS PAID INFORMATION AND TO DEVELOP A "PROFILE" ON THE PROVIDER OR PHYSICIAN. THE PATTERN OF PRACTICE OF THE PROVIDER OR PHYSICIAN IS COMPARED TO OTHER SIMILAR PROVIDERS AND PHYSICIANS TO IDENTIFY POTENTIALLY ABUSIVE ACTIVITIES. THESE ACTIVITIES COULD INVOLVE OVER UTILIZATION OF SERVICES, UPCODING OF SERVICES TO INCREASE PAYMENTS, AND VIOLATIONS OF THE PHYSICIAN'S MAXIMUM CHARGE LEVEL.

PHYSICIANS AND SUPPLIERS WHO ARE IDENTIFIED IN THIS POSTPAYMENT REVIEW PROCESS UNDERGO A SERIES OF CORRECTIVE POST-PAYMENT ACTION INITIATIVES INCLUDING EDUCATIONAL CONTACTS, INCREASED PREPAYMENT SCRUTINY, AND WARNING NOTICES. IF THE PROBLEM IS NOT CORRECTED THROUGH THESE MEANS, THE CONTRACTOR IS REQUIRED TO REFER THE PROBLEM TO THE OFFICE OF INSPECTOR GENERAL. DEPENDING ON THE NATURE AND EXTENT OF THE PROBLEM, WE MAY IMPOSE A MONETARY SANCTION, EXCLUDE THE PHYSICIAN OR PROVIDER FROM MEDICARE PARTICIPATION, OR REFER THE CASE FOR CRIMINAL PROSECUTION.

TWO OTHER ACTIVITIES ROUND OUT CONTRACTOR PAYMENT SAFEGUARDS: THE RESOLUTION OF BENEFICIARY COMPLAINTS AND PERIODIC AUDITS OF PROVIDER CLAIMS.

EXAMPLES

CONTRACTORS ARE REQUIRED TO WORK CLOSELY WITH THE OFFICE OF INSPECTOR GENERAL (OIG) IN IDENTIFYING AND ASSISTING IN THE INVESTIGATION OF CASES OF FRAUD AND ABUSE IN THE MEDICARE PROGRAM. LET ME ELABORATE ON SOME EXAMPLES OF HOW WE HAVE WORKED TOGETHER IN THIS AREA.

- FROM YOUR HOME STATE, MR. CHAIRMAN, THE BLUE CROSS AND BLUE SHIELD OF IOWA BROUGHT TO OUR ATTENTION A CASE WHERE A PROVIDER WAS BILLING MEDICARE FOR HOME HEALTH SERVICES WHILE PATIENTS WERE ACTUALLY IN A HOSPITAL. WE ARE CONDUCTING A CRIMINAL INVESTIGATION ON THE AGENCY WHICH COULD LEAD TO A CONVICTION.

- IN ANOTHER STATE, THE CARRIER ESTIMATED THAT A PLASTIC SURGEON FALSELY BILLED OVER $1.5 MILLION TO MEDICARE OVER A 2-YEAR PERIOD. THE SURGEON, WHO ONLY TREATED HOSPITAL AND NURSING HOME PATIENTS

WITH SKIN ULCERS, UPGRADED THE BILLING CODE FOR HIS SERVICES AND EXAGGERATED THE NUMBER OF LESIONS HE TREATED. HE WAS SENTENCED TO 6 MONTHS IN A HALFWAY HOUSE, FINED $10,000 AND PLACED ON 5-YEAR PROBATION. IT IS DOUBTFUL THAT THE $1.5 MILLION CAN EVER BY RECOVERED.

- FINALLY, IN ONE OF TWO ONGOING CASES, A FEDERAL GRAND JURY RECENTLY INDICTED THE OWNERS AND OPERATORS OF A DURABLE MEDICAL EQUIPMENT (DME) COMPANY SPECIALIZING IN SEAT LIFT CHAIRS. THE COMPANY'S MARKETING STRATEGY SPECIFICALLY TARGETED MEDICARE PATIENTS BY PURCHASING TELEPHONE LISTS OF PERSONS OVER 65. COMPANY PERSONNEL WOULD CALL THE BENEFICIARIES AND TELL THEM THAT SEAT LIFT CHAIRS COULD BE SUPPLIED IN THEIR HOMES AT NO COST. THEY WOULD OBTAIN THE BENEFICIARY'S ATTENDING PHYSICIAN NAME FROM THEM. THE COMPANY WOULD THEN PREPARE THE AUTHORIZATION DOCUMENTS NEEDED TO BILL THE EQUIPMENT TO MEDICARE. THEY OFTEN LISTED DME WHICH THE BENEFICIARY HAD NOT REQUESTED, AND SHOWED GREATLY EXAGGERATED DIAGNOSES. THEY INTIMIDATED ATTENDING PHYSICIANS TO SIGN THE CONTRIVED AUTHORIZATIONS, SOMETIMES USING THREATS OF PATIENT LOSS OR LAWSUITS. THE PROVIDER EVEN FORMED A MOBILE DIAGNOSTIC CARE COMPANY AND HIRED CERTAIN PHYSICIANS TO SIGN THE AUTHORIZATIONS FOR BENEFICIARIES WHOSE DOCTORS REFUSED TO DO SO. SOME BENEFICIARIES NEVER RECEIVED THE CHAIR. OTHERS RECEIVED A SECONDHAND CHAIR, EVEN THOUGH MEDICARE PAYS FOR NEW EQUIPMENT. WE BELIEVE THAT OVER $400,000 IN FALSE CLAIMS WAS PAID TO THIS ONE COMPANY ALONE. OUR INVESTIGATION OF THIS COMPANY

COULD NOT HAVE BEEN DONE AS SUCCESSFULLY AS IT WAS WITHOUT THE ASSISTANCE OF THE CONTRACTOR.

WE CAN CITE OTHER INSTANCES WHICH DEMONSTRATE HOW WE WORK WITH CONTRACTORS TO CONTROL THE COSTS AND OVER UTILIZATION OF ITEMS AND SERVICES IN THE MEDICARE PROGRAM. SIMILAR FINDINGS ARE APPEARING IN OUR WORK ON POWER-OPERATED VEHICLES AND TRANSCUTANEOUS NERVE STIMULATION DEVICES (TENS).

HOWEVER, THEIR PERFORMANCE, THOUGH IMPROVING, IS NOT WITHOUT FAULT. WE BELIEVE THAT THERE ARE SEVERAL SIGNIFICANT AREAS IN WHICH HCFA AND THE MEDICARE CONTRACTORS COULD IMPROVE THEIR EFFECTIVENESS AND EFFICIENCY WITHOUT REDUCING THEIR PERFORMANCE OR ACHIEVEMENTS.

PROBLEMS

THE OIG HAS A RESPONSIBILITY TO MONITOR CONTRACTORS PERFORMANCE. TO ACHIEVE THIS GOAL WE RELY ON OUR AUDIT AND INSPECTION FINDINGS AS WELL AS ON HCFA REPORTS AND DATA. FOR EXAMPLE, HCFA PRODUCES ANNUALLY ITS CONTRACTOR EVALUATION REPORT WHICH HIGHLIGHTS THE SUCCESSES AS WELL AS THE PROBLEMS STILL FOUND IN THIS PROGRAM. THIS ANNUAL REPORT FOCUSES ON CARRIER PERFORMANCE IN SUCH AREAS AS CLAIMS PROCESSING, BENEFICIARY SERVICES, PRODUCTIVITY INVESTMENTS, FISCAL AND CONTRACT MANAGEMENT AND PAYMENT SAFEGUARDS. SOME OF THE PROBLEMS NOTED FROM RECENT REPORTS INCLUDE:

- AN INCREASE IN THE NUMBER OF APPEALS AND REVERSALS OF CLAIMS DENIED BY PREPAYMENT REVIEW. OVER THE PAST 4 YEARS, CARRIERS HAVE BEEN CONSISTENTLY LOSING MORE THAN HALF OF THE APPEALED DENIALS. THE NUMBER OF APPEALS HAS DOUBLED BETWEEN 1984 AND 1988 TO A LEVEL OF 5.7 MILLION. IN 1988, THE DENIALS WERE REVERSED ON $296 MILLION WORTH OF CLAIMS.

- AN INCREASE IN THE NUMBER OF CLAIMS DENIED THROUGH THE PREPAYMENT EDIT PROCESS WHICH ARE LATER REPROCESSED AND PAID. THE INITIAL DENIALS CREATES THE ILLUSION OF SAVINGS, BUT THE ADDITIONAL WORK ACTUALLY ADDS TO MEDICARE CLAIMS PROCESSING COSTS.

WE HAVE ALSO UNCOVERED PROBLEMS WITH THE MEDICARE CONTRACTORS PROGRAM. IN AN AUGUST 1988 INSPECTION WE FOUND THAT:

- MANY CARRIERS WERE NOT FOLLOWING HCFA POLICIES AND PROCEDURES REGARDING CARRIERS' PAYMENT SAFEGUARD FUNCTIONS, AND THAT
  - -- POST-PAYMENT CASES WERE CLOSED WITHOUT EFFECTING THE NECESSARY CORRECTIONS,
  - -- CASES WHICH SHOULD HAVE BEEN REFERRED TO OIG WERE NOT REFERRED.

- BOTH HCFA AND THE CARRIERS PLACED THEIR EMPHASIS ON PREPAYMENT REVIEWS AND PLACED A LOW PRIORITY ON IDENTIFYING AND RESOLVING POST-PAYMENT CASES. AS A RESULT, MANY CARRIERS WERE BEHIND IN THEIR REVIEW PROCESS AND WERE NOT RESOLVING CASES WITHIN THE 1-YEAR TIME FRAME REQUIRED.

- OVERALL FUNDING FOR CARRIERS DID NOT APPEAR TO BE A SERIOUS PROBLEM FOR THEIR PAYMENT SAFEGUARD FUNCTIONS AT THAT TIME. HOWEVER, MUCH OF THE FUNDING INTENDED FOR PROGRAM INTEGRITY FUNCTIONS WAS SPENT ON VARIOUS OPERATIONS NOT RELATED TO IDENTIFICATION AND RESOLUTION OF FRAUD AND ABUSE CASES. WE ARE CONCERNED THAT THIS MAY BE GRADUALLY ERODING THE EFFECTIVENESS OF THE PROGRAM INTEGRITY EFFORT.

FROM OUR PAST EXPERIENCE WITH A VARIETY OF MEDICARE CONTRACTORS, WE HAVE FOUND THAT ALTHOUGH MEDICARE CONTRACTORS HAVE DEMONSTRATED A TREND TOWARD INCREASING THE NUMBER OF INSTANCES OF POSSIBLE FRAUD REFERRED TO THE OIG FOR INVESTIGATION, THE ACTUAL NUMBER OF SUCH REFERRALS WHICH HAVE LED TO SUCCESSFUL CRIMINAL OR CIVIL ADJUDICATIONS HAS BEEN DISAPPOINTING.

IN ADDITION, OUR INVESTIGATIONS OF CERTAIN REFERRALS HAVE SHOWN THAT CONTRACTOR PERSONNEL WERE AWARE, THROUGH BENEFICIARY COMPLAINTS AND CLAIMS REVIEW ACTIVITIES THAT FRAUD OR ABUSE WAS OCCURRING BUT TOOK NO ACTION TO IDENTIFY OR STOP IT. WE HAVE IDENTIFIED INSTANCES IN WHICH CONTRACTOR PERSONNEL HAVE KNOWN THAT A CLAIM WAS ALTERED, BUT CONTINUED TO PAY THE CLAIM AND DID NOT NOTIFY THE OIG. AS A RESULT, MANY CONTRACTORS ARE LESS THAN AGGRESSIVE IN IDENTIFYING AND REPORTING FRAUDULENT CASES.

ACCORDING TO OUR RECORDS, THE MEDICARE CONTRACTORS REFER TO THE OIG AN AVERAGE OF ABOUT 400 ALLEGATIONS OF POSSIBLE FRAUD PER YEAR. MOST OF THE ALLEGATIONS REFERRED TO US ARE OF LOW QUALITY OR ARE INADEQUATELY DEVELOPED. THERE ARE EXCEPTIONS. IN THE PAST 4 YEARS 6 PERCENT OF THE AGGREGATE CONTRACTOR REFERRALS RESULTED IN CRIMINAL CONVICTIONS AND CIVIL SETTLEMENTS. THE 10 PERCENT OF CONTRACTORS WHO CONSISTENTLY REFER WELL FOUNDED ALLEGATIONS TO OUR OFFICE, HAVE A SUCCESSFUL ACTION RATE AS HIGH AS 20 PERCENT. MOST OF OUR INITIAL LEADS FOR INVESTIGATIONS, HOWEVER, COME FROM A SOURCE OTHER THAN THE MEDICARE CONTRACTOR. FOR EXAMPLE, OUR INITIAL SEAT LIFT CHAIR INVESTIGATION IN NEW YORK FOR WHICH WE GOT EXTENSIVE SUPPORT AND HELP FROM THE CARRIERS ONCE THE INVESTIGATION WAS UNDERWAY, WAS INITIATED AT THE REQUEST OF CONGRESSMAN FRANK HORTON OF NEW YORK.

SEAT LIFT CHAIRS

CONCURRENT WITH OUR INVESTIGATION OF SEAT LIFT CHAIRS WE ALSO UNDERTOOK AN INSPECTION ON SEAT LIFT CHAIRS (SLCs) AND AUDITED ONE LARGE SUPPLIER OF SEAT LIFT CHAIRS. WE FOUND STRONG INDICATIONS THAT THEY DO NOT QUALIFY FOR MEDICARE COVERAGE AS DME.

HCFA DEFINES DME AS "...EQUIPMENT WHICH (1) CAN WITHSTAND REPEATED USE, (2) IS PRIMARILY AND CUSTOMARILY USED TO SERVE A MEDICAL PURPOSE, (3) GENERALLY IS NOT USEFUL TO A PERSON IN THE ABSENCE OF ILLNESS OR INJURY, AND (4) IS APPROPRIATE FOR USE IN THE HOME." ALL OF THE ELEMENTS OF THE DEFINITION MUST BE MET IN ORDER FOR THE EQUIPMENT TO BE COVERED BY MEDICARE. OUR INSPECTION FOUND, HOWEVER, THAT MOST OF THE PERSONS RESPONDING TO OUR SURVEY USED SEAT LIFT CHAIRS FOR NON-MEDICAL PURPOSES AND MANY INDICATED THAT THEY NEEDED NO HELP IN STANDING UP. FURTHER, MOST OF BENEFICIARIES WHO RESPONDED SAID THEY LEARNED ABOUT THEIR SEAT LIFT CHAIRS THROUGH THE AGGRESSIVE MARKETING OF SUPPLIERS. SIXTY PERCENT OF THE BENEFICIARIES CONTACTED SAID THE SUPPLIER TOLD THEM THAT THEY WOULD NOT HAVE TO PAY ANYTHING TOWARDS THE $700-800 CHARGE FOR A CHAIR. WE ALSO LEARNED THAT PHYSICIANS FREQUENTLY AUTHORIZED SLCs UNDER PRESSURE FROM BENEFICIARIES.

OUR INSPECTION REPORT RECOMMENDED THAT HCFA RECONSIDER WHETHER SLCs MEET THE MEDICARE DEFINITION OF DME. FURTHER, WE RECOMMENDED THAT HCFA SHOULD: A) DISSEMINATE THE "BEST PRACTICES INFORMATION" WE IDENTIFIED TO ASSURE THAT CURRENT COVERAGE REQUIREMENTS ARE MET; B) IMPLEMENT THE OMNIBUS BUDGET RECONCILIATION ACT OF 1987 (OBRA-1987) PROVISION PROHIBITING PAYMENT FOR DME UNLESS THE SUPPLIER HAS RECEIVED A WRITTEN ORDER FROM THE PHYSICIAN BEFORE DELIVERY OF THE ITEM; C) INSTRUCT CARRIERS TO DEVELOP AND REFER SANCTION

RECOMMENDATIONS TO US REGARDING PHYSICIANS WITH PATTERNS OF UNNECESSARILY PRESCRIBING SLCs; D) DIRECT CARRIERS TC ENFORCE THE ROUTINE WAIVER PROVISION; E) INSTRUCT CARRIERS TO REFER TO OIG FOR CIVIL MONEY PENALTY ACTION SUPPLIERS WHO ADVERTISE "MEDICARE-APPROVED" IN VIOLATION OF THE MEDICARE CATASTROPHIC COVERAGE ACT OF 1988; AND F) EXPEDITE ITS REVIEW OF THE CARRIER JURISDICTION ISSUE AND RESOLVE THE PROBLEM OF OUT-OF-SERVICE-AREA CLAIMS.

HCFA ESSENTIALLY AGREED WITH THE FINDINGS OF OUR INSPECTION REPORT AND HAS BEGUN A NUMBER OF ACTIONS TO IMPLEMENT THE RECOMMENDATIONS. CURRENTLY, A DRAFT FEDERAL REGISTER NOTICE ADDRESSES COVERAGE ISSUES RELATING TO SLCs IS BEING CLEARED WITHIN HCFA. WITH YOUR PERMISSION, I WOULD LIKE TO INSERT COPIES OF THE FINAL INSPECTION REPORT AND DRAFT AUDIT REPORT INSERTED IN THE RECORD.

NEW THREATS TO UTILIZATION

OUR CONCERNS WITH MEDICARE CONTRACTORS TAKE ON ALARMING AND NEW MEANING IN LIGHT OF THE GROWING SOPHISTICATION BEING DEMONSTRATED BY PHYSICIANS AND PROVIDERS BILLING MEDICARE. MEDICARE PART B PAYMENTS WHICH INCLUDE PAYMENTS FOR PHYSICIAN SERVICES, LABORATORY SERVICES AND DURABLE MEDICAL EQUIPMENT HAVE INCREASED 15 PERCENT PER YEAR FOR THE LAST 5 YEARS. MORE THAN HALF OF THIS INCREASE IS DUE TO GROWING UTILIZATION OF LABORATORIES, NEW SURGICAL TECHNIQUES, EXTENSIVE TECHNOLOGY AND REACTION BY PHYSICIANS AND PROVIDERS TO MEDICARE COST CONTAINMENT EFFORTS OF THE PAST SEVERAL YEARS. IN ADDITION, DESPITE THE CURRENT PAYMENT SAFEGUARD ACTIVITIES, THE COMBINATION OF AGGRESSIVE MARKETING TECHNIQUES AND NEW PHYSICIAN OWNERSHIP ARRANGEMENTS WITH DIAGNOSTIC TESTING SERVICES MAY BE CAUSING AN INCREASE IN THE UNNECESSARY UTILIZATION OF FEDERAL HEALTH CARE FUNDS.

CONCLUSION

BEFORE CLOSING, LET ME SAY THAT AS WE CONTINUE TO MONITOR WHAT MEDICARE CONTRACTORS AND HCFA ARE DOING TO REDUCE FRAUD AND ABUSE IN THE MEDICARE PROGRAM WE WILL CONTINUE TO FIND WAYS TO MAKE THEM MORE EFFECTIVE AND EFFICIENT. WORKING WITH HCFA AND THE CONTRACTORS LAST YEAR ALLOWED US TO INTRODUCE NEW TECHNIQUES IN THEIR PRE AND POST PAYMENT PROCESSES TO BETTER IDENTIFY BAD CLAIMS. IN ADDITION, THERE APPEARS TO BE A NEW AWARENESS OF THE NEED TO IMPROVE THEIR PERFORMANCE IN THE PAYMENT SAFEGUARD AREA. WE BELIEVE THAT THERE IS STILL ROOM FOR SIGNIFICANT IMPROVEMENT IN THEIR CLAIMS PROCESSING AND PAYMENT SAFEGUARD FUNCTIONS. FURTHER, WE BELIEVE THAT EVEN GREATER SAVINGS ARE ACHIEVABLE THROUGH THEIR AUDIT AND SECOND PAYER ACTIVITIES.

THIS CONCLUDES MY TESTIMONY. I AM PLEASED TO ANSWER ANY QUESTIONS YOU MAY HAVE.

MEMORANDUM FROM RICHARD P. KUSSEROW

FEB 7 1989

Richard P. Kusserow
Inspector General

Draft Report on the Audit of Medicare Part B Payments for Seat Lift Chairs to Queen City Home Health Care by Nationwide Mutual Insurance Company - CIN: A-05-87-00138

William L. Roper, M.D.
Administrator
Health Care Financing Administration

Attached for your review and comment is a copy of the subject draft report. The purpose of this review was to determine whether Nationwide Mutual Insurance Company (Nationwide) was paying for seat lift chairs in accordance with current Health Care Financing Administration (HCFA) coverage instructions and at reasonable payment levels. We extended the review to evaluate the effectiveness of coverage instructions to screen for only medically necessary seat lift chairs. The review concentrated on Queen City Home Health Care (Queen City), a major supplier of seat lift chairs, for claims processed during the period January 1, 1984 through June 30, 1987.

Payments for seat lift chairs have been dramatically increasing primarily due to the aggressive mass marketing techniques of suppliers and because suppliers such as Queen City prepare statements of medical necessity for physicians. For example, Queen City's billings for seat lift chairs increased from $8.9 million in 1984 to approximately $37.3 million in 1985. The billings for the first 6 months of 1987 were $16.3 million. Carriers, physicians, and beneficiaries have complained about the practices employed by Queen City to solicit business and secure coverage documentation required by HCFA. Although the documentation was sufficient to comply with coverage requirements, there was concern that the seat lift chairs were not medically necessary and were not being used by beneficiaries as part of their medical treatment.

Our review found other carriers were concerned that supplier initiated statements of medical necessity may not accurately reflect the need for a seat lift chair, even though the statements were signed by a physician. Blue Cross and Blue Shield of Texas, Inc. (BCBST) was one such carrier but they took action to revise their instructions for payment approval. The new BCBST instructions require that the physician initiate the order for a seat lift chair and provide additional evidence of the medical necessity for the seat lift chair. This approach has dramatically reduced the payments for seat lift chairs from approximately $7.3 million to $10,700 annually. This same approach at other carriers could have similar results.

We also found that allowing carriers to process claims for beneficiaries not located in their servicing area

contributes to paying for chairs which may not be medically necessary. For example, Queen City, who solicits patients throughout the country, submits all their claims for payment to Nationwide. Nationwide, however, only maintains claims histories for beneficiaries in their contractual jurisdiction. By not having claims history files available for screening, a carrier is not able to identify other types of equipment paid by other Medicare carriers which serve a purpose contrary to a seat lift chair. For the claims that Nationwide was able to screen, from November 1985 through November 1987, it denied over $1 million in payments. A change to require carriers to only process claims for beneficiaries in their service area should result in additional denials and cost savings.

We also determined based on Queen City cost data and the durable medical equipment (DME) industry standard markup that the payment rate for seat lift chairs was unreasonably high. Additionally, Medicare payments to Queen City under the recently enacted Omnibus Budget Reconciliation Act of 1987 (OBRA 87) could be even higher. The potential payments in excess of the reasonable payment level presented in our report could be $6.1 million, or as much as $44.9 million, depending upon which OBRA provision is applied. The OBRA 87 also restricts the use of inherent reasonableness payment provisions until 1991.

We are recommending HCFA strengthen coverage instructions and enforce controls by requiring the physician to originate the order and by prohibiting suppliers from assisting in the preparation of supporting documentation. The HCFA should require physicians and suppliers to sign a certification acknowledging that any intentional misrepresentation of fact constitutes fraud and may subject them to prosecution and/or the imposition of civil monetary penalties. Furthermore, the HCFA should consider using objective standards for determining medical necessity of the seat lift chairs, such as the results of specified medical tests. The HCFA should also require carriers to only process claims for beneficiaries in their servicing area thus allowing full screening for contraindicated equipment. Consideration should also be given to legislative proposals to allow the continued use of the inherent reasonableness provisions and to require physicians, who order unnecessary medical equipment, to make a refund.

If you or your staff wish to discuss the material contained in this report, please let me know or contact Thomas D. Roslewicz, Assistant Inspector General for Audit. We would appreciate your comments within 30 days from the date of this memorandum.

Attachment

AUDIT OF MEDICARE PART B PAYMENTS FOR SEAT LIFT CHAIRS TO QUEEN CITY HOME HEALTH CARE

NATIONWIDE MUTUAL INSURANCE COMPANY

COLUMBUS, OHIO

NOTICE

"This draft of a proposed Office of Audit report is being made available for review and comment by officials having management responsibilities concerning the matters presented. This draft report is not to be considered final as it is subject to further review and revision. Please adequately safeguard this document against unauthorized use."

OFFICE OF INSPECTOR GENERAL

OFFICE OF AUDIT

CIN: A-05-87-00138

SUMMARY

This draft audit report provides the results of our review of Medicare payments made by Nationwide Mutual Insurance Company (Nationwide) for seat lift chairs. The review covered payments made during the period January 1, 1984 through June 30, 1987 with emphasis on payments to Queen City Home Health Care (Queen City), a major supplier of seat lift chairs. The purpose of the review was to determine whether Nationwide was paying for seat lift chairs in accordance with current Health Care Financing Administration (HCFA) coverage instructions and at reasonable charge levels.

We also extended our review to evaluate the effectiveness of coverage instructions to screen for only medically necessary seat lift chairs. The strengthening of procedures and coverage instructions and adoption of certain legislative proposals could substantially reduce the significant expenditures for seat lift chairs, which was never intended to be more than a limited purpose benefit. We also believe that requiring carriers to process claims for beneficiaries located in their jurisdictional servicing area would improve coverage determinations. Additionally, we found that current payments for seat lift chairs could be lowered if carriers could apply inherent reasonableness provisions.

With respect to applying HCFA coverage requirements, Nationwide did receive documentation which contained technical language to satisfy coverage. However, the documentation submitted is supplier initiated and may not accurately reflect the medical necessity for the seat lift chair. Nationwide merely requires that the physician sign the supplier initiated statement of medical necessity. Some physicians will sign the statement primarily to satisfy their patients. Coverage guidelines do not require physicians to personally complete the statement of medical necessity. Furthermore, these guidelines do not require objective medical tests or independent verification of data furnished in the statements of medical necessity. As a result, Queen City's billings for seat lift chairs increased from $8.9 million in 1984 to an estimated $32 million in 1987.

Converse to the payment history for seat lift chairs at Nationwide, when Blue Cross and Blue Shield of Texas, Inc. (BCBST), the Texas carrier, performed an independent utilization review of the medical necessity for selected seat lift chair claims, it noted many cases for which coverage criteria were not actually met. Therefore, it revised its payment procedures and virtually eliminated payments for seat lift chairs. Payments by BCBST were reduced from $7.3 million for the year ended June 30, 1987 to $10,700 for the year ended June 30, 1988. A similar approach by Nationwide could have the same results.

Nationwide processes all claims submitted by Queen City. Because Queen City obtains clients nationally through mass marketing techniques, Nationwide is not able to fully screen beneficiary claims histories for medical necessity. Nationwide only maintains claims history files for those beneficiaries in the two States under its contractual responsibility and does not have claims histories for beneficiaries residing throughout the country. When Nationwide has been able to screen claims history files for other items of equipment which serve a purpose contrary to the purpose of a seat lift chair, they have denied medically unnecessary claims amounting to $1 million during the period November 1985 through November 1987. A Medicare reimbursement change to require carriers to only process claims for beneficiaries in their service area should result in additional denials and cost savings.

The current Medicare reasonable charge to Queen City for a seat lift chair is $891.95. If financial information obtained from Queen City is representative, the reasonable charge payment based on inherent reasonableness criteria could be lowered to $639. However, the provisions of the Omnibus Budget Reconciliation Act of 1987 (OBRA 87) preclude applying inherent reasonableness tests until 1991. Also, when OBRA 87 is implemented in January 1989, payments to Queen City are expected to increase. As a result, payments to Queen City could increase $6.1 million or as much as $44.9 million in excess of the reasonable payment level as determined by the Office of Inspector General.

We are recommending HCFA strengthen claims processing procedures and coverage instructions, change the carrier jurisdictional requirements for the processing and screening of supplier claims, and establish a more

reasonable level of payment. In regard to procedures and coverage instructions, physicians should be required to complete the statement of medical necessity, and durable medical equipment (DME) suppliers should be prohibited from assisting in its preparation. Physicians and suppliers should be required to sign a certification that they understand that the misrepresentation of facts may subject them to prosecution and/or the imposition of civil monetary penalties. The physician's medical evaluations and the statement of medical necessity should be based on objective standards, such as the results of specified medical tests. The HCFA instructions should require the physician to certify that he is the patient's attending physician, that the seat lift is medically necessary, and that it is a part of the patient's ongoing course of treatment. Furthermore, HCFA should consider legislation to require physicians, who order unnecessary medical equipment, to be penalized in the amount of the original payment. In relation to jurisdictional responsibilities for processing and screening of supplier claims, the carrier responsible for processing the claim should be the carrier for the location in which the beneficiary lives. In addition, HCFA should consider legislation to allow carriers to continue to establish reasonable payment levels for seat lift chairs.

INTRODUCTION

BACKGROUND

Part B of the Medicare program provides medical insurance coverage to help pay for physician services, outpatient services and other health services and supplies. The Medicare Coverage Issues Manual, HCFA Publication No. 6 (formerly Chapter II - Coverage Issues Appendix to Medicare Carriers Manual (MCM), Section 60-8), incorporates seat lift chairs as an allowable DME expenditure by stating:

> "Reimbursement may be made for the rental or purchase of a medically necessary seat lift when prescribed by a physician for a patient with severe arthritis of the hip or knee and patients with muscular dystrophy or other neuromuscular diseases when it has been determined the patient can benefit therapeutically from use of the device. In establishing medical necessity for the seat lift, the evidence must show that the item is included in the physician's course of treatment, that it is likely to effect improvement, or arrest or retard deterioration in the patient's condition, and that the severity of the condition is such that the alternative would be chair or bed confinement...."

We examined the coverage guidelines and payments for seat lift chairs made by Nationwide, a Medicare Part B carrier. Particular focus was placed on Queen City, a major supplier of seat lift chairs. The purpose of the review was to determine whether Nationwide was appropriately processing Queen City's DME claims for seat lift chairs in accordance with HCFA's regulations and policies for coverage and at reasonable charge levels.

SCOPE

Our review was conducted in accordance with generally accepted government auditing standards. We focused on whether Nationwide was processing seat lift claims in accordance with existing coverage instructions and at reasonable payment levels. We extended our audit procedures to evaluate the effectiveness of carrier instructions to screen claims and pay for only medically necessary seat lift chairs. The review was performed on a selective basis and included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances.

Our review of internal controls was limited to a review of the procedures employed by Nationwide to process claims for seat lift chairs with particular emphasis on Queen City's claims. Because the audit could be performed more efficiently through the use of substantive tests, a complete review of internal controls was not performed. Although we concluded that Nationwide obtained and utilized documentation to process claims as required by HCFA's coverage instructions, we identified potential vulnerabilities in the physician medical necessity certification process and the carrier's procedures for screening claims for beneficiaries billed outside its service area. Our examination would not necessarily disclose all material weaknesses in the system, and we do not express an opinion on the internal controls taken as a whole or on any of the control areas reviewed.

Our review covered the period January 1, 1984 through June 30, 1987. It was conducted at Nationwide in Columbus, Ohio, and included site visits at the office of Queen City (Cincinnati, Ohio) and the HCFA Regional Office.

At Nationwide, our audit included a random sample of claims for seat lift chairs submitted by Queen City for each of the calendar years covered by the audit. The claims and supporting documentation were examined to determine whether the physicians identified on the statements of medical necessity were actually licensed and whether the available documentation adequately supported that coverage criteria were met before claims were accepted for payment. We also contacted physicians and beneficiaries to confirm claim information previously provided. In addition, we judgementally selected seat lift chair claims from other suppliers to assure a consistent application of coverage criteria to all suppliers.

Our review at Queen City was restricted by the supplier. Because of the pending court case[1] on inherent reasonableness, Queen City would not provide access to most of its records. We did examine vouchers and invoices for the purchase of chairs, take a tour of the facility, and receive an oral presentation of procedures and document flow associated with taking orders and processing claims. Procedures for handling complaints were reviewed, and a sample of complaints obtained from Nationwide were compared

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[1] Association of Seat Lift Manufacturers v. Bowen, No. 87-3149 (6th Cir.) September 23, 1988.

with Queen City's records to ascertain adequacy of resolution.

At the HCFA Regional Office, we examined related files and discussed HCFA's actions and position with respect to seat lift chair claims.

We also contacted the Manager of DME and Part B Overpayments at BCBST to discuss and gain an understanding of its claims processing procedures with respect to seat lift chairs and to determine what impact changes in these procedures had on the number of claims allowed.

In October 1988 the Office of Inspector General issued a draft report titled "Medicare Coverage of Seat Lift Chairs." This draft report recommended, in part, that HCFA reconsider whether seat lift chairs meet the definition of durable medical equipment. If HCFA rules that seat lift chairs are not DME and, therefore, not covered for payment, the recommendations proposed in this report would not be necessary.

The review was performed during the period September 1987 through July 1988.

FINDINGS AND RECOMMENDATIONS

MEDICARE COVERAGE

Marketing Practices/Claims Processing

Queen City and other DME suppliers use mass TV advertising, newspapers, and toll-free telephone numbers to solicit orders from Medicare beneficiaries for seat lift chairs. Advertisements generally state that the chair may be received at no cost if a person is enrolled in Medicare Part B; has a Medicare coinsurance policy; and has a qualifying medical condition. These ads generate a considerable response. For example, Queen City has over 60 operators to take incoming calls and increased its billings for seat lift chairs from $8.9 million in calendar year 1984 to approximately $37.3 million in 1985. Billings dropped to $7.9 million in 1986 with changes in Nationwide's review procedures and in the rate of reimbursement but increased to $16.3 million in the first half of 1987. The number of claims for seat lift chairs submitted during the audit period increased as a direct result of the marketing techniques and claims processing procedures employed by Queen City and other DME suppliers.

When a customer contacts Queen City, an operator inquires about the caller's medical condition and Medicare eligibility and obtains the name and address of the caller's physician. The operator then contacts the physician's office to verify the diagnosis and to get the necessary medical information to complete the statement of medical necessity. Medicare Part B coverage is verified by Queen City through the use of a computer information service having access to beneficiary eligibility files in the HCFA Hospital Insurance Mini Master System. If coverage criteria are met, a statement of medical necessity

is prepared by Queen City using preselected statements. This standard form is sent to the physician for signature. When the signed copy is received, the order is sent to a warehouse for delivery, and the billing is sent to Nationwide for payment.

Queen City and other DME suppliers have, in effect, circumvented the intended process for ordering medical equipment. Instead of the attending physician initiating a prescription or a statement of medical necessity based on his knowledge and experience with the use of the chair by other patients, the current practice is for Queen City to make the initial contact with the beneficiary and to prepare a pro forma statement of medical necessity for the signature of the beneficiary's physician. This practice reverses procedures normally employed to prescribe the majority of other equipment, such as wheelchairs and hospital beds.

We have been told by a number of physicians that this practice places the physician in an awkward position and encourages some physicians to certify medical necessity without fully evaluating their patients. Even though a physician assumes responsibility for statements on coverage criteria when signing the statement of medical necessity, many physicians will sign the statement of medical necessity primarily to satisfy their patient. For example, one physician stated that his records on a particular patient were very brief and that he was probably talked into signing the statement of medical necessity. He also stated that on occasion patients have come to his office to have statements of medical necessity signed and if he was reluctant to sign they would cause such a commotion that often his only alternative was to sign. Carriers have also received complaints from physicians that they are being pressured to sign the statement of medical necessity. In addition, we found instances where physicians had not seen their patients for years or had never seen the patients until they were approached for their authorization of the seat lift chair and they signed the statement of medical necessity. It is, therefore, probable that seat lift chairs are being prescribed which are not medically necessary.

To judge the effectiveness of the coverage procedures used at Nationwide, we contacted the Texas Medicare carrier, BCBST, who implemented stronger review instructions on payments for seat lift chairs. Concerned with the increasing utilization of seat lift chairs, BCBST began questioning whether the seat lift chairs being claimed were medically necessary. The BCBST initiated utilization reviews which focused on determining whether coverage criteria were actually met or were merely indicated as met on the statement of medical necessity. The reviews found that many chairs were not being used, that patients were not bed or chair confined, and that patients were able to get in and out of conventional chairs without assistance. Furthermore, the physicians' medical records did not contain formal plans of treatment which included the use of the seat lift chairs. As a result of these reviews, BCBST identified medically unnecessary payments, changed its claims processing procedures with respect to seat lift chairs, and implemented a new Certification of Medical Necessity for Seat Lift Chairs.

Under BCBST's revised procedures, the patient's attending physician must complete the new certificate of medical necessity, which is much more comprehensive than the one previously used, and a medical review by a BCBST physician determines whether coverage conditions are met. The new certificate of medical necessity requires, among other things, that the physician explain his involvement with the patient, describe his plan of treatment and its effect on the diagnosis, explain the seat lift chair's therapeutic value to the patient, and state whether the patient can get out of a conventional chair without assistance. The form also includes a warning to the physician that intentional misrepresentation of facts constitutes fraud and may subject the physician to prosecution and/or the imposition of civil money penalties by the Federal Government. It also requires the physician to certify that his records are available for review. The manager at the Texas carrier, with whom we spoke, indicated that the implementation of these new procedures has substantially reduced the payments for seat lift chairs. Payments were reduced from approximately $7.3 million for the fiscal year ended June 30, 1987 to $10,700 for the fiscal year ended June 30, 1988.

Based on the effectiveness of the BCBST procedures, we believe they should be incorporated by HCFA into strengthened national coverage instructions and certification controls over the ordering of seat lift chairs. Since physicians are ultimately responsible for making the determination of medical necessity, they should be the party initiating the authorization without any undue influence from suppliers or patients. Physicians should be informed of these responsibilities under the program and be held accountable for their actions. Both physicians and suppliers need to be made aware of the provisions of Section 1128(b)(6) of the Social Security Act, enacted as part of the Medicare and Medicaid Patient and Program Protection Act, which could subject them to exclusion from the program for ordering or causing to be ordered medically unnecessary services. The HCFA should also consider requiring that the results of specific medical tests, to measure the severity of the patient's condition and need for a seat lift chair, be included with the claim, thereby providing a more objective basis for determining coverage. In addition, the HCFA should propose legislation to require physicians, who order unnecessary medical equipment, to be penalized in the amount of the payment for the equipment.

Claims Review/Jurisdictional Responsibility

In an effort to control the number of claims submitted for seat lift chairs, Nationwide established system checks or edits to identify previous DME purchases in the claims history which were provided for medical purposes contrary to the intended purpose of the seat lift chair. Claims for seat lift chairs are initially rejected and subject to subsequent medical review when the beneficiary's previous medical needs contradict the required purpose of the seat lift chair (to assist in continuing mobility versus providing mobility). The DME is not covered by Medicare unless it is medically necessary. Therefore, edits were established to check claims for seat lift chairs, hand powered and motorized wheelchairs, roll about chairs and

geriatric chairs against a beneficiary's claims history for a claim for one of the other coded items. If any of the related items are found, then the claim being processed is further reviewed to determine if the seat lift chair is intended for a purpose similar to the previously paid item. Although Nationwide implemented the edits on August 1985 and denied $1,041,853 in claims during the period November 1985 through November 1987, these edits were only effective for claims for beneficiaries living in Nationwide's area of contractual responsibility. This area and Nationwide's claims history files are limited primarily to the Medicare beneficiaries in Ohio and West Virginia. Regulations requiring the timely processing of clean claims prevent Nationwide from obtaining claims history data from other carriers in time to run edit checks and process the claims in a timely manner.

Under current Medicare guidelines, the site where a DME supplier meets with a beneficiary or receives the beneficiary's order determines jurisdiction for processing a supplier's claims even if a supplier has branch offices or sales/rental outlets in more than one jurisdiction. Although Queen City maintains three out-of-State warehouses, it conducts business and makes all its sales (mostly through telephone contacts) from a central office in Cincinnati, Ohio. Queen City does not maintain any sales outlets or sales representatives outside of Ohio. As a result, Nationwide is required to process all of Queen City's claims. Since Queen City submits claims for beneficiaries living throughout the country, a significant number of claims cannot be checked for conflicting equipment. For these edits to be most effective, claims histories for all beneficiaries should be examined. If the seat lift chair claims were processed at the carrier for the area in which the beneficiary resides, previous DME and physician claims would be available for expanded comparison of claims for possible contradictory medical purposes and for evidence that the physician authorizing the seat lift chair is an attending physician of the beneficiary.

The HCFA should consider changing the jurisdictional requirements for the processing of claims to have carriers only process claims for beneficiaries in their service area. Additional denials and cost savings similar to that experienced at Nationwide should result.

MEDICARE REIMBURSEMENT

Although Nationwide has implemented inherent reasonableness criteria to reduce the rate of reimbursement for seat lift chairs, Queen City's costs and industry mark-up practices of DME indicate further reduction could be warranted. Effective August 19, 1985, Nationwide used inherent reasonableness criteria to establish a reasonable charge level for the seat lift chairs of $869.51. This substantially reduced the amount previously paid for these chairs. Effective January 1, 1987, the inherent reasonableness charge was increased to $891.95. Although a Nationwide manager indicated the rate might be too high and may need to be reevaluated, this amount has not been reviewed or updated since it was established. Nationwide reimburses Queen City for most seat lift chairs on a purchase basis rather than on a rental basis.

We reviewed Queen City vouchers and invoices for seat lift chairs and determined that the price per chair ranged from $280 to $400 during calendar year 1987 and early 1988. We also determined the average cost of a chair in inventory at November 30, 1987 was $326. Using the Medicare Carriers Manual percentage of 66 2/3 as the DME industry's standard mark-up, and adding shipping, labor for assembly, and sales tax to the average cost per chair, we computed a reasonable reimbursement rate of $639. This rate is nearly $253 less than the current inherent reasonable charge of $891.95 established by Nationwide.

Under OBRA 87 (P.L.100-203), Section 4062, the method of payment for seat lift chairs will change effective January 1, 1989. This provision will require that payments for seat lift chairs be made under one of two categories, either as routinely purchased DME or other items of DME. If it is determined that seat lift chairs are purchased at least 75 percent of the time, the transaction will be classified as an inexpensive or other routinely purchased DME and payment could be made on a purchase or rental basis. The purchase price will be established based on the average allowed charge for the purchase of the item during the 12-month period ended June 30, 1987, indexed to December 1987. The rental payment will be limited to the purchase price. If it is determined that seat lift chairs are purchased less than 75 percent of the time, the seat lift chairs will be classified as other items of DME and the payment will be made on a capped rental basis. For 1989, the capped monthly payments are computed based on 10 percent of the recognized local purchase price, with up to 15 consecutive monthly payments permitted. This recognized local purchase price is the weighted average of the purchase price on claims submitted on an assignment-related basis during the six-month period ending December 1986, increased by the consumer price index for the 6-month period ended December 1987. This amount cannot be greater than 115 percent or less than 85 percent of the prevailing rental charge of the item as of January 1987, increased by the consumer price index for the 6-month period ended December 1987. The total payment amount, based on the weighted average of submitted charges but limited by the ceiling payment amount as calculated under this methodology, would be substantially higher than the current payment using the inherent reasonableness rate. The OBRA 87 provisions also prohibit HCFA from applying the inherent reasonableness provisions of Section 1842(b)(8) before January 1, 1991.

The HCFA is currently in the process of determining which payment methodology will be applied to seat lift chairs. Based on our contacts with Nationwide, the payment under the inexpensive or other routinely purchased DME methodology could approximate $896 and payment under the capped rental methodology could be approximately $2,544. These amounts are in excess of our calculation of the reasonable payment level of $639. In the first half of 1987, Queen City was reimbursed for approximately 11,796 seat lift chairs. Under the OBRA 87 provisions and based on annualized 1987 volume levels, payments to Queen City could be $6.1 million or as much as $44.9 million in excess of the reasonable payment level as determined by the Office of Inspector General (see Appendix A). As previously

explained, OBRA 87 would preclude inherent reasonableness reductions to these increased expenditures until 1991.

We have concluded that the increased expenditures for seat lift chairs is attributable to: (1) aggressive television marketing techniques, (2) acceptance of supplier initiated statements of medical necessity, (3) lack of strong objective coverage instructions and enforcement controls, and (4) carriers processing claims for beneficiaries outside their jurisdictional service areas. Queen City's mass marketing practices as described and its practice to supply physicians with documented statements of medical necessity to sign has dramatically increased the claims volume. Nationwide's processing of claims without use of beneficiary histories has also contributed to increased use and overutilization of a benefit that was never intended to be more than a limited coverage item. In addition, the amount of payment for seat lift chairs, using the inherent reasonableness criteria or the payment provisions under OBRA 87, may be too high. The increased demand for the chairs has enabled Queen City to obtain seat lift chairs at significantly reduced prices without any corresponding decrease in the inherent reasonable rate of payment.

RECOMMENDATIONS

We recommend that HCFA:

1. Implement the Texas procedures by,

   (a) requiring that the physician order originate from the attending physician and be prepared on this physician's letterhead;

   (b) designing a revised certificate of medical necessity form requiring the attending physician to explain:

      (1) his/her involvement
      (2) plan of treatment
      (3) whether patient can get out of a conventional chair; and

   (c) requiring a warning letter in the certificate of medical necessity that intentional misrepresentation of facts constitutes fraud and may subject the physician to prosecution and/or civil monetary penalties.

2. Initiate legislative changes to,

   (a) prohibit DME suppliers from assisting in the preparation of any materials documenting the medical necessity for the item, with civil monetary penalties to both the physician and supplier for violation;

   (b) require physicians who order medically unnecessary equipment to refund payment; and

   (c) apply inherent reasonableness provisions effective January 1, 1989.

3. Designate the contractor that handles claims for the area in which the beneficiary resides as the carrier responsible for processing claims for seat lift chairs. The processing of claims by the beneficiary's local carrier will permit increased screening for contraindicated equipment and evidence of treatment by the authorizing physician.

OTHER MATTERS

Since the completion of our field work, Queen City has appealed the application of the inherent reasonableness rate to the level of an administrative law judge. It is Queen City's contention that, since its advertising costs are higher than most suppliers, a reimbursement rate of $1,249 would be more reasonable than the inherent reasonableness rate of $892, established by Nationwide. With a potential adjustment of $357 ($1,249 - $892) on approximately 60,000 claims, Queen City could receive an additional $21.4 million in reimbursement. This additional reimbursement to Queen City would be above the substantial amounts already paid in excess of amounts computed on the basis of the reasonable reimbursement rate presented in this report. This situation further illustrates the need for HCFA to defend the use of inherent reasonableness pricing, to pursue its continued use, and to consider any other actions necessary to control the reimbursements for seat lift chairs.

APPENDIX A

SCHEDULE OF POTENTIAL MEDICARE PAYMENTS
TO QUEEN CITY FOR SEAT LIFT CHAIR CLAIMS
UNDER PROVISIONS OF OMNIBUS BUDGET RECONCILIATION ACT OF 1987

	OBRA of 1987 Payment Methodology		
	Inexpensive Or Other Routinely Purchased DME	Capped Rental	Auditor's Computed Reasonable Payment Level
Number of seat lift chairs for which Queen City was reimbursed during the period January 1987 through June 1987 (a)	11,796	11,796	11,796
Annualized number of seat lift chairs for 1987 (a) x 2	23,592	23,592	23,592
Total payment amounts	$ 896	$ 2,544	$ 639
Potential payments under stated methodologies	$ 21,138,432	$ 60,018,048	$ 15,075,288
Reasonable payment computed by auditor	15,075,288	15,075,288	
Potential payments in excess of reasonable payment computed by auditor	$ 6,063,144	$ 44,942,760	

NOTE: The difference between the potential payment under the OBRA 87 routinely purchased DME payment methodology and the payment amount using the current inherent reasonable rate of $892 is $38,973,984 ($60,018,048 - $21,044,064).

MEDICARE COVERAGE OF SEAT LIFT CHAIRS

EXECUTIVE SUMMARY

PURPOSE

The purpose of this study was to review the Medicare program's experience in responding to the high volume of claims being received for seat lift chairs.

BACKGROUND

A seat lift chair (SLC) is a mechanized lounge chair, similar to a *La-Z-Boy* chair, that is mechanically controlled to assist the person in standing up and sitting down alone. The SLC has been covered by the Medicare program as durable medical equipment (DME) since 1978. The Health Care Financing Administration (HCFA) defines DME as: "... equipment which (1) can withstand repeated use, (2) is primarily and customarily used to serve a medical purpose, (3) generally is not useful to a person in the absence of illness or injury, and (4) is appropriate for use in the home." All elements of the definition must be met in order for the equipment to be covered by Medicare.

Prior to 1986, HCFA restricted Medicare coverage of SLCs to patients with severe arthritis of the hip or knee, muscular dystrophy, or other neuromuscular diseases. In 1986, HCFA amended its policy to tie coverage of SLCs directly to medical necessity rather than diagnostic categories.

Nationally, in 1985, the number of SLC claims received tripled--from about 200,000 in 1984 to about 700,000--and allowed charges went from $33.7 million to $63.3 million. This experience revealed that the aggressive national marketing by suppliers of SLCs had given rise to a Medicare beneficiary "consumerism" in which beneficiaries were initiating requests for SLCs. It also raised questions about the adequacy of SLC coverage guidelines and the role of physicians in authorizing them.

METHODOLOGY

Two samples were selected: 8 Medicare carriers; and 97 beneficiaries for whom a SLC claim was paid by Medicare in 1986. Site visits were made to the 8 carriers where discussions were held and case records for 161 selected 1987 paid claims were reviewed. In addition, telephone discussions were held with 107 respondents, including 61 seat lift chair beneficiaries, 7 family members of beneficiaries and 39 physicians who authorized chairs for some of the beneficiaries.

FINDINGS

There are strong indications that seat lift chairs do not qualify as durable medical equipment under the Medicare program.

- Most beneficiaries' comments indicated that the SLCs were used primarily for non-medical purposes, such as personal comfort, and can be useful to persons in the absence of illness or injury. Between 31 percent and 44 percent did not require assistance in getting up from bed, table or toilet, and most of those said they were able to walk around their home, many without assistance. Most of the remaining beneficiaries were either unable to walk at all or went from the SLC to a wheelchair or power-operated vehicle in order to move about their homes. Since two of the four elements which define DME frequently are not met, there appears to be no basis for covering SLCs as DME under the Medicare program.

- Over 85 percent of the 61 beneficiaries contacted stated they initiated the request for seat lift chairs. Most said they learned about them through aggressive mass media marketing by suppliers.

- Sixty percent of the 61 beneficiaries said the supplier told them they would not have to pay anything, and 69 percent said they never made payments (i.e., for coinsurance or deductibles owed).

- Beneficiaries' physicians were often authorizing SLCs under pressure from both beneficiaries and suppliers, rather than as part of an existing course of treatment. In nearly half the 161 cases reviewed on-site, the SLCs were actually delivered before the chair was prescribed by a physician.

The HCFA has recognized vulnerabilities related to SLC claims and has taken aggressive action; nevertheless, more effective payment safeguards need to be implemented.

- More rigorous SLC claims review by Medicare carriers, in response to timely HCFA directives and guidance, resulted in significant reductions in SLC reimbursement after 1985.

- The question of carrier jurisdiction, already under review by HCFA, needs to be resolved to avoid out-of-service-area claims for which carriers lack beneficiary history data needed to prevent duplicate claims and to identify claims for contraindicated DME.

- Some carrier best practices for more effective evaluation of SLC claims need to be shared.

RECOMMENDATIONS

1. Coverage of SLCs

In light of the strong evidence that most SLCs appear to be used primarily as furniture, HCFA should reconsider whether SLCs, in fact, meet the Medicare definition of DME.

2. Payment safeguards

a) Immediate steps should be taken by HCFA to further improve the effectiveness of carrier processing of SLC claims. The HCFA should disseminate to its carriers best practices identified in this inspection which help to assure that current coverage requirements for SLCs are met. These include having carriers review beneficiaries' claims histories to:

- determine whether the authorizing physician for the SLC had previously treated the beneficiary to help ascertain whether a course of treatment including a SLC was initiated prior to its authorization and delivery.

- ascertain whether the beneficiary has a wheelchair and, if so, whether the SLC should also be covered.

b) The HCFA should implement the OBRA 1987 provision prohibiting payment for DME unless the supplier has received a written order from the physician before delivery of the item to the patient.

c) The HCFA should instruct carriers to develop and refer sanction recommendations to the OIG when carriers have identified physicians with patterns of unnecessarily prescribing SLCs.

d) The HCFA should direct carriers to enforce the provisions of the Medicare Carriers Manual, section 5220, by allowing only those charges which the supplier expects to receive when they routinely waive collection of coinsurance and deductible payments. Suppliers found to have routinely advertised a general intention to waive such payments or to have failed to make reasonable collection efforts should be referred to the OIG for sanctions.

e) The HCFA should also instruct carriers to refer to the OIG for civil money penalty action in which suppliers advertise SLCs as being "Medicare-approved" or "endorsed" or "authorized" in violation of the Medicare Catastrophic Coverage Act of 1988.

f) The HCFA should expedite its review of the carrier jurisdiction issue and resolve the problem of out-of-service-area claims which denies carriers data essential to assuring the integrity of SLC and other claims.

COMMENTS ON DRAFT REPORT

Comments received from the Administrator of HCFA indicate essential agreement with the findings. The HCFA reports it has begun a number of actions to implement the OIG recommendations, including:

- development of a draft *Federal Register* notice that addresses coverage issues relating to SLCs (recommendation 1);

- disseminating best practices information to the carriers (recommendation 2a);

- preparing regulations to implement section 1834 of the Omnibus Budget Reconciliation Act of 1987. The regulations will include SLCs as one of the items for which the supplier must have received a physician's written order before the item is delivered to the patient (recommendation 2b);

- instructing carriers, effective for services rendered on or after January 1, 1989, to require that the suppliers have a written order in hand prior to delivery of the equipment to the beneficiary (recommendation 2b);

- instructing the carriers to conduct an indepth medical review of all SLC claims (recommendation 2c); and

- reviewing the issues of carriers' jurisdiction in order to look at ways to resolve the problems of out-of-service area claims (recommendation 2f).

The HCFA also suggested that the OIG take vigorous action to curb abuses regarding SLCs noted in the report. We have expanded our recommendations to reflect such concerns expressed by HCFA and the OIG's Office of Investigations. However, before the OIG can act, cases must be referred to it by HCFA and its carriers through increased diligence in identifying instances of routine waiver of coinsurance and of suppliers who misuse the word "Medicare" in advertisements.

INTRODUCTION

BACKGROUND

"When I saw the TV advertisement I felt that I wanted it (the seat lift chair) because it was getting to the point where I was having difficulty getting out of a chair by myself."

This statement, obtained during the research for this inspection, was made by a Medicare beneficiary who was able to walk unassisted around her apartment, had a home health aide daily and had ordered the chair through a national supplier of medical equipment. When her physician was interviewed he verified that he had not initiated the order for the seat lift chair (SLC): "I did not order the chair and I can't say that it's part of my course of treatment, but the chair has been helpful to her."

Numerous complaints about SLCs received and investigated by the OIG kindled concern over the rapidly growing number of claims being received for SLCs apparently in response to aggressive marketing efforts by suppliers. This concern prompted this inspection.

Medicare coverage of seat lift chairs

Durable medical equipment (DME) is defined by the Health Care Financing Administration (HCFA) as: "... equipment which (1) can withstand repeated use, (2) is primarily and customarily used to serve a medical purpose, (3) generally is not useful to a person in the absence of illness or injury, and (4) is appropriate for use in the home." All of the elements of the definition must be met in order for the equipment to be covered by Medicare.

A seat lift chair, or SLC, is a mechanized lounge chair, similar to a *La-Z-Boy* chair, that is mechanically controlled to assist the person in standing up and sitting down unassisted. The HCFA's current coverage policy and contractor guidelines for the SLC are based in part on a June 1978 Public Health Service (PHS) assessment requested by HCFA. The PHS offered the opinion that the chair "seems to be equipment presumptively medical" similar to hospital beds and wheelchairs, and as such should be covered as DME. This is in contrast to items which HCFA has determined to be "presumptively nonmedical," i.e., items that basically serve a comfort or convenience purpose, such as stairway elevators, posture chairs, bathtub lifts and seats, lounge beds (power or manual) and raised toilet seats. Such items are not covered as DME.

Prior to 1986, Medicare coverage of SLCs was restricted to patients with severe arthritis of the hip or knee, muscular dystrophy, or other neuromuscular diseases. In 1986, HCFA clarified its policy to tie coverage of SLCs directly to medical necessity rather than diagnostic categories.

In order for a SLC to be covered, it is required that:

- a physician determines that a patient can benefit therapeutically from its use;
- the SLC is included in the physician's course of treatment and is likely to effect improvement or arrest or retard deterioration in the patient's condition, and
- the severity of the condition is such that the alternative would be chair or bed confinement.

Medicare carriers are responsible to see that these coverage requirements are met before approving payment. Payments are most frequently made under assignment to the SLC supplier, who is paid 80 percent of the allowable charge. The beneficiary is then responsible for paying the 20 percent coinsurance to the supplier. The purchase allowance for a SLC, which varies by carrier, ranged from $697 to $1,795 in September 1987; the average allowance was $906.41. At that time, the allowable monthly charge for renting a SLC ranged from $40 to $162.

HCFA and OIG Concerns

In May 1985, the HCFA Director of the Bureau of Eligibility, Reimbursement and Coverage issued a Medicare Coverage Alert on SLCs to HCFA Regional Administrators. The alert mentioned an extensive advertising campaign for "Medicare-approved" seat lift chairs that was resulting in numerous claims being submitted. Nationally, the number of SLC claims went from about 200,000 in 1984 to about 700,000 in 1985, and allowed charges went from $33.7 million in 1984 to $63.3 million in 1985.

In June 1985, the HCFA Bureau of Program Operations asked regional HCFA staff to conduct a survey of carriers' experiences in reimbursing claims for SLCs, "... so that, if necessary, more precise national procedures could be developed." The survey revealed that SLC coverage and reimbursement rules were being abused. Many more Medicare beneficiaries were obtaining SLCs than HCFA expected on the basis of existing guidelines and coverage criteria.

The OIG's Office of Investigations in New York, working with a large local carrier, helped devise a questionnaire to be completed by the prescribing physician after a SLC claim was submitted and before it was paid. This questionnaire solicited information for the carrier's medical staff on the medical necessity and appropriateness of the chair. This project resulted in a denial rate of 98.6 percent of the claims (1,198 of 1,215) submitted within an 8-week period in 1985 and a savings of $910,480.

When later adopted by several other Region II carriers, the questionnaire again resulted in a very high rate of denials (82 percent) for 44,150 claims submitted for the first three quarters of Fiscal Year (FY) 1986 (a savings of nearly $8.5 million). This encouraged HCFA and its carriers to implement similar claims development procedures. The use of a uniform national questionnaire was, however, not mandated and not every carrier followed the Region II example.

The experience of 1984 to 1986 showed that the aggressive national marketing of SLCs had given rise to a Medicare beneficiary "consumerism" in which beneficiaries were apparently initiating the medical authorization process for this equipment. It also raised questions about the adequacy of SLC coverage guidelines as well as the role of physicians in authorizing them.

OBJECTIVES

- Describe the nature of beneficiary responses to the marketing by suppliers of seat lift chairs.
- Assess the role of physicians when their patients wish to obtain seat lift chairs under Medicare.
- Describe and characterize the nature of the response of HCFA and its carriers to the increase in the volume of seat lift chair claims.
- Identify those factors which raise particular concerns about SLC coverage and related Medicare policies and procedures.

METHODOLOGY

Overview

Site visits were made to 8 Medicare carriers where discussions were held with a total of 31 individuals and selected case records were reviewed. Respondents included 22 managers and supervisors and 9 staff members, among them claims examiners and Fair Hearing officers. Telephone discussions were held with 107 respondents, including 61 seat lift chair beneficiaries, 7 family members of beneficiaries and 39 physicians who had authorized chairs. Laws, regulations, HCFA correspondence, guidelines and special studies, as well as carrier and supplier forms and related materials were also reviewed.

Samples and respondents

Two samples were drawn: a stratified purposive sample of carriers; and a random sample of beneficiaries for whom a SLC claim was paid by Medicare in 1986. More specifically, 8 Medicare carriers were selected from a universe of 35 carriers nationwide, stratified according to high, medium and low amounts of dollars allowed for SLCs. Two carriers were selected from the low group. Each of the of the sample carriers in turn provided a randomly selected group of 100 approved 1987 claims. From these, 161 claims (about 20 for each carrier) were randomly selected by the study team for on-site review while examining the carrier's SLC claims review procedures.

The second sample, consisting of 97 beneficiaries whose SLC claims were paid in 1986, was randomly selected from HCFA's Part B Medicare Annual Data base (BMAD) for all carriers. Sample represented 25 from as many States around the country. Out of these 97 potential respondents, 68 contacts were made: 61 telephone discussions were held directly with beneficiaries and 7 with the spouses or children of deceased beneficiaries. From the initial sample of 97 beneficiaries, 50 beneficiaries were selected and an effort was made to contact the 50 physicians who authorized the SLCs for those beneficiaries. Thirty-nine were successfully contacted by telephone. These contacts resulted in 30 matched pairs of beneficiaries and their physicians with whom separate discussions were held.

FINDINGS

There are strong indications that seat lift chairs do not qualify as durable medical equipment under the Medicare program.

The SLC is used primarily as furniture.

The fact that a SLC can serve a non-medical purpose as furniture is one characteristic which raises a question about its qualifying as DME under Medicare. The SLC can serve as a comfortable and attractive piece of furniture, much as a recliner. Its only distinguishing feature from an ordinary chair is that it has a mechanism which assists a person in sitting down and standing up. This circumstance appears to contradict one element of HCFA's definition of DME: that it would not be generally useful to a person in the absence of illness or injury.

As far back as 1984, a question was raised by a carrier's associate medical director on whether the SLC was primarily a therapeutically beneficial piece of medical equipment or a convenient piece of furniture. In a July 1984 letter to a member of Congress, he argued that the therapeutic value of the SLC does not meet HCFA's requirements that the patient can benefit therapeutically from use of the device:

> "In my opinion, the key word here is therapeutic. I see no way that a chair of any kind can be said to have a part in the therapy or treatment of a patient's disease or disorder. No matter how I look at it, the seat lift chair is still an item of furniture. It may be handy; it may be convenient; and it may be desirable, but I do not view this as a part of *a course of treatment prescribed by a physician* for any named disorder, disease or disability. It seems to me that if we provide a seat lift for all of aged people who are crippled up with arthritis and others who are simply too old and weak to get out of a chair alone or at least without considerable trouble, that we are going to be spending an awful lot of money for some expensive equipment that really was not intended to be a part of the Medicare Program, which so greatly benefits our aged population. The more money we spend on things like this, the less there is going to be available for really necessary, truly medical care services and equipment."

In 1987 this physician wrote again to HCFA regarding SLCs and complained about the marketing techniques of suppliers and their effect on physician practice:

> "I write this time over my personal private practice letterhead and personal signature to make a strong complaint as a practicing physician and as a tax-paying citizen of this country about the possibility of the Medicare Program providing reimbursement for this item of durable equipment. This is almost fraud, if not fraud, the way these people solicit our beneficiaries and the way they fill out all these forms in a way that no really practical practicing physician would complete them. You will notice that the language is almost exactly, if not exactly, that of the printed regulations. They have obviously constructed a piece of paper here and a completed form deliberately patterned after the regulations and not after the facts in any particular case.... They send them to the physicians, and naturally most of the busy physicians, even if they are fairly alert and even if they are fairly experienced, will believe that the Congress intended their patient to have the benefit of this kind of device.... I doubt if any particular physician ... has any idea how much is being spent on durable medical equipment and how much of that is indeed strictly a luxury or buying furniture and not *medically* necessary.... I was hopeful that after our last session on this subject the regulation of authorizing the payment for these chairs would be substantially modified and clarified or even eliminated all together."

The following comments by some beneficiaries provide insights into the SLC's function as furniture:

> "The chair is fine but it's too big for my living room. It's beautiful, like a piece of furniture."
>
> "It's a very wonderful piece of furniture."
>
> "It is very beautiful, but I regret not having one that reclines as well as lifts up."
>
> "The seat lift chair is a good, sturdy chair and comes in handy."
>
> "It's very handy and is very comfortable. It also has nice material."

One of the physicians who acknowledged that a chair was not part of his course of treatment for his patient said, "It's more of a convenience."

Some beneficiaries did not appear to be benefitting therapeutically from their SLC.

The therapeutic value of a SLC ostensibly consists in helping a patient stand up in order to walk, so as to correct or stabilize the patient's condition and prevent confinement to bed or hospitalization. However, 18 percent of the 68 beneficiaries contacted said they were not able to walk around their home, even with assistance. Further, as many as 44 percent said that they didn't need assistance, either in standing when getting up from the table or when getting up from the toilet. Thirty-one percent said they didn't need help to stand when getting out of bed.

Some beneficiaries told us or the carriers of cases where the chair was not used or was not considered useful after delivery:

> "I've never been satisfied with [it]," one beneficiary said. "My hips hurt me worst when I'm just sitting in it than when I sit in my recliner. I have been waiting for a letter from Medicare so I could tell my story.... I really hate the chair."

Another beneficiary wrote to the Medicare carrier:

> "I'd like you to send someone to pick the chair up. It's very hard, and I can't put my left foot up. I used the chair about 15 minutes. It's new, I kept it covered."

There is little in what we learned from beneficiaries and physicians that supports any distinction between SLCs and, for example, posture chairs and lounge beds, items judged by HCFA to be "presumptively nonmedical" and not covered as DME by Medicare. On the contrary, there is compelling evidence that SLCs are not primarily serving a medical purpose and can be useful to a person in the absence of illness or injury; hence, there appears to be no basis for SLCs to be considered DME under Medicare provisions.

Beneficiaries learn about SLCs from advertisements and take the initiative to obtain chairs.

When the 61 beneficiaries were asked, "How did you first learn about the seat lift chair you obtained?" 73 percent said they heard about it through supplier advertising; most mentioned television as a source with a smaller number mentioning suppliers' salespersons. Of those not mentioning advertising, 15 percent said they learned through family or friends; only 12 percent said they learned about the SLCs from a doctor.

Respondent comments, as well as study observations of television and brochure advertisements reveal that the ads commonly refer to the SLC as "Medicare-approved" and imply there may be no cost to the beneficiary. Indeed, 60 percent of the 67 beneficiaries who dealt with the suppliers, usually on a toll-free telephone number displayed in the ad, reported that the suppliers said they wouldn't have to pay anything for a SLC, suggesting the suppliers would be willing to forego the 20 percent coinsurance. One carrier's claims review supervisor told of seeing a television ad recently in which the announcer said that all one needed to do was call and order the chair if one had Medicare; no mention was made of the need for medical authorization.

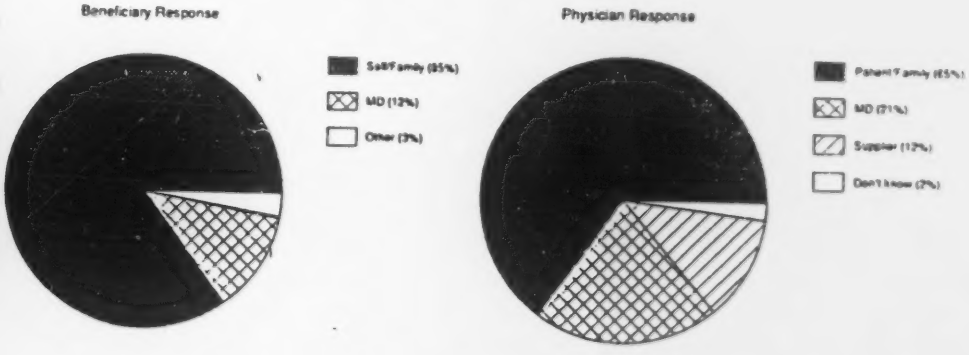
The degree to which suppliers are aggressively marketing seat lift chairs is reflected in the statement of one doctor: "There have been chair companies calling people and telling them all they have to do is buy the chair and then have the doctor okay it and Medicare will pay." One beneficiary said she ordered a chair through a television ad and, before she could contact her doctor, the chair was delivered to her home (within a few hours).

It should be noted that the Medicare Catastrophic Coverage Act of 1988, effective after the field work for this study was completed, prohibits the "use, in connection with any item constituting an advertisement ... the (word) 'Medicare'... in a manner which such person knows or should know would carry the false impression that such item is approved, endorsed, or authorized by the ... Health Care Financing Administration." Civil money penalties can be levied against violators.

Most patients say getting the chair was their idea.

Unlike most ordering of medicines or other DME, requests for SLCs tend to be initiated by the patient and subsequently authorized by the doctor. As shown in figure 1, 85 percent of the contacted beneficiaries said it was either their own idea or their family's idea to get a SLC. Only 12 percent stated it was their doctor's idea.

Figure 1
Whose Idea Was It to Get a Seat Lift Chair?



One woman stated: "My mother and I were together when we saw the announcement (about the SLC) on television. We made the decision to purchase the chair and ordered it."

The physician responses in figure 1 confirm this reversal of roles - 65 percent of the 39 physicians confirmed it was their patient's idea.

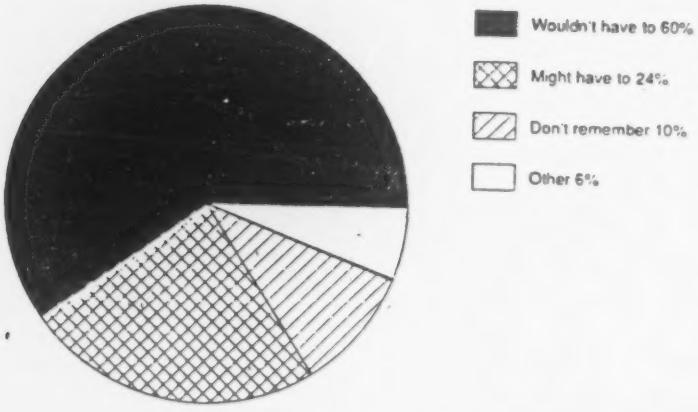
Most beneficiaries were told they would not have to pay for SLCs.

Eighty-four percent of the beneficiaries contacted said they were told they would not, or might or might not have to pay anything for their SLC; and 69 percent of them said they did not pay anything.

As shown in figure 2, 60 percent of the beneficiaries reported that the suppliers advised them they would not have to pay anything; another 24 percent were told they might or might not have to pay anything, 10 percent could not remember what they were told; and 6 percent gave other responses, e.g., their children had taken care of their finances for them.

Figure 2

What Supplier Told Beneficiaries About Whether They Would Have to Pay for SLC



When beneficiaries were asked whether they actually paid anything for their chair, 69 percent said no; a quarter said they paid something and 6 percent could not remember. While a few beneficiaries said the supplier kept billing them, the great majority did not report any supplier efforts to collect coinsurance or deductible payments. While nearly two-thirds of the beneficiaries said their policy paid something for their SLC and 30 percent said they did not know. The majority, 58 percent, said their insurance did not pay anything.

The HCFA had given specific instructions to its regional offices in a May 1985 memorandum concerning SLCs to have carriers "enforce vigorously the ground rules in MCM (Medicare Carriers Manual) section 5220 when suppliers, including suppliers of seat lift chairs, routinely waive the collection of coinsurance or deductible amounts." The appropriate carrier action in response to such instances was to assure that:

> "(1) the amount allowed on current claims should not exceed the amount the supplier actually expects to receive; and (2) the correct actual charges should be recorded and accumulated for use in future updates of the supplier's customary charge profile. The supplier should, of course, be notified."

The beneficiary responses indicate that some such action by carriers may have been warranted.

Many physicians authorize SLCs in response to beneficiary or supplier requests.

The physician interviews indicated that SLC approvals are often responses to patient or family requests rather than professional treatment decisions of the physician. One doctor, when asked if he initiated the authorization for the seat lift chair, said: "The chair was her request and I authorized it to help her get up and watch television."
While most physicians contacted did not report being pressured into prescribing the chair, nearly one-fifth did admit pressure from the patient or the family. One said:

> "This is a small town and everyone knows me. I have been treating Mrs. "X" for 5 years. When the supplier called to say he needed an authorized form for the chair Mrs."X" had ordered, I was very uncomfortable. Then her daughter called to say her mother needed the chair and I should give it to her. I signed."

Another physician spoke of pressure from both patients and suppliers:

> "The supplier tells the beneficiary that if their doctor fills in the right information on related illnesses, coverable by the Medicare program, they can get a seat lift chair. The patient pressures the doctor as does the supplier, putting the doctor in the middle."

Other physicians, however, noted that they sometimes turn down requests for chairs. One doctor, for example, said: "I've turned down patients who ask for them because I felt they didn't need them."

Suppliers frequently provide authorization forms for doctors to sign. Most (58 percent) of the physicians contacted reported that suppliers provided forms or suggested the words to use. Another 32 percent said both they and the suppliers play a part in completing the forms. Only 8 percent wrote an authorization without any supplier involvement.

Suppliers have been accused, by some physicians interviewed, of soliciting SLC business from Medicare beneficiaries and then sending authorization forms to the beneficiaries' physicians without the knowledge or permission of the beneficiaries.

Including a SLC in beneficiary's course of treatment often appears to be a physician justification after the fact.

An important requirement for SLC coverage is that the SLC be part of the physician's course of treatment. Five physicians (13 percent) of those contacted acknowledged that the SLC was not part of their course of treatment. When they were asked if the SLC was intended as part of the patients course of treatment, several remarked as follows:

> "No, the patient is not ambulatory but the alternative would be a nursing home."

> "The patient wanted the chair and her daughter felt it would help when mom is in the living room watching T.V."

> "It (the authorization form) does look like my signature but I have no records regarding authorizing a chair and I wouldn't."

Eighty-four percent of the physicians said the chair was intended for use as part of their course of treatment for their patients. However, a comparison of the date the physician authorized the chair with the date of service, i.e., the date the chair was delivered, showed that in nearly half (48 percent) of 141 cases reviewed on-site, for which both dates were available, the date

of delivery occurred before the chair was authorized. The course of treatment in these cases, rather than preceding the ordering of the SLC, may not have been developed until after the chair was ordered.

One physician expressed the view that "doctors should not be put in a position to rubber stamp an authorization because DME has been ordered by a patient and already delivered, and now the patient states that Medicare will pay 80 percent if the doctor would just sign."

Some physicians also play a passive role in following up on the patient's use of a SLC and on any therapeutic value the chair may have had. After an interval of 1 1/2 to 2 1/2 years following their authorization of a SLC, 44 percent of physicians contacted said they had not spoken to their patient about whether the seat lift chair was helpful. Another 10 percent didn't remember whether they had or not. Although 84 percent of the physicians had seen their patient subsequent to authorizing the SLC, 27 percent did not know whether the chair had any effect on the patient's condition. A large number of physicians profess ignorance of what Medicare coverage guidelines are for SLCs. As a matter of fact, when asked whether they felt this authorization of a SLC for their patients met Medicare guidelines, nearly half (46 percent) said they didn't know the guidelines.

Medicare is the most prominent payer for SLCs.

Commercial insurance members of the National Health Insurance Association of America do not ordinarily offer coverage for DME, particularly SLCs. In order to provide such coverage, a rider would be added to policies if subscribers were willing to pay substantially higher premiums. The National Association of Blue Cross and Blue Shield reported that its plans do not cover SLCs for private policy holders. The Veterans Administration (VA) does cover SLCs under very stringent controls. All prescriptions are reviewed by a VA physician and the VA's Chief of Prosthetics to assure that like other types of medical equipment, SLCs will be "furnished when it is medically necessary and not for the convenience of life outside the hospital." The volume of SLCs approved by the VA for 1987, primarily for patients with prosthetic limbs, was only 200. A survey of the nation's eight largest State Medicaid plans revealed that only two cover SLCs. In those States, prior approval under stringent medical necessity guidelines is required.

The HCFA has recognized vulnerabilities related to SLC claims and has taken aggressive action; nevertheless, more effective payment safeguards need to be implemented.

Carriers alerted by HCFA to take action.

Coverage of SLCs was not seen as a serious problem by HCFA until early 1985, when a remarkable increase in SLC claims and reimbursement was noted: SLC claims rose 240 percent from 205,800 in 1984 to 700,600 in 1985. The amounts allowed for SLCs rose 94 percent from $33,750,653 in 1984 to $63,360,201 in 1985.

In June 1985, HCFA notified its regional offices to have carriers review SLC claims more closely. The HCFA also surveyed carriers to learn how SLC claims were being handled. The survey results, reflected in a November 1985 memorandum, indicated "... this coverage area continues to be a source of potential program abuse although current coverage policy indicates seat lifts are to be covered only in very limited situations." Regional offices were advised to encourage carriers to develop a "... special purpose claims development and certification form when requesting additional information from physicians." Such a form was already in use by 11 carriers and a model was attached to the memorandum for carrier use. A list of "Claims Review Criteria for High Cost Durable Medical Equipment Claims" was also provided.

Carrier review efforts reduced amounts allowed by 1986 and carriers continue to apply coverage guidelines.

Nationally, the timely actions taken by HCFA and carriers in 1985 and 1986 were largely responsible for the 66 percent drop in volume of SLC claims to 236,013 in 1986 and the 55 percent drop in allowances in 1986 to $28,304,558. The dollar amounts allowed illustrate how effective the actions by HCFA and carriers have apparently been. Nationally, more than half (56 percent) of the carriers reduced the amounts allowed in 1986. The eight sample carriers showed allowances for SLCs dropping in 1986 to $4,488,000 from $25,175,000 in 1985.

The results of the eight carrier site visits show that carriers continue to apply SLC coverage guidelines, although the efforts of some are more rigorous than others. Three carriers use medical staff personnel to review SLC claims to determine their appropriateness; five use non-medical staff personnel, usually a claims examiners. One medical director said that "the non-medical staff are capable of making coverage decisions and the carrier couldn't afford to pay [the medical director's] salary to review such claims." However, seven carriers use medical personnel to review questionable claims including denied SLC claims going to fair hearings.

A best practice was seen at six carriers where claims examiners check beneficiaries' claims histories to determine whether the beneficiaries also have wheelchairs. The possession of a wheelchair and a SLC, from the carriers' perspective, is generally contraindicated, based on the reasoning that the therapeutic benefit of the chair, if any, resides only in its ability to get the patient into a standing position so he or she can ambulate (with or without assistance). If the patient is helped to a standing position only to sit down again in a wheelchair, that patient would be chair-ridden even with the SLC. At best, the SLC would have limited value in allowing the brief stretching of the patient's legs before the patient is again chair-ridden.

Of the 68 patients or family members contacted in 1988, 9 percent volunteered that the beneficiary also had a wheelchair. When their Medicare claims histories were reviewed for 1986 (the year they received their SLC), we found that an additional three percent obtained wheelchairs in that year alone. A recent postpayment audit conducted by a sample carrier of one supplier found that 56 of 72 beneficiaries with SLCs also had wheelchairs. As a consequence of this study the carrier expanded the audit and reviewed a sample of 257 beneficiaries who reside within the State or in several neighboring States. Forty-five percent of the SLCs were denied as not medically necessary and a refund of over half a million dollars was established.

An emergent problem, however, is that the prepayment checking of beneficiary claims histories is difficult when the beneficiary resides outside the carrier's service area, a frequent circumstance. Six of the carriers who review beneficiary claims histories in-house do not obtain out-of-area claims histories from other carriers. Their reason is they cannot wait for the information on an otherwise "clean" SLC claim which must be processed under stringent payment cycle standards.

There is concern over carrier claims jurisdictional issues and the problems they generate, particularly when SLCs are involved. Extensive supplier national media advertising frequently results in carriers paying SLC claims for beneficiaries out of their service area for whom they have no claims histories, possibly resulting in unidentified duplicate claims. In addition, carrier reasonable charge allowances are sometimes higher for out-of-area beneficiaries whose claims would have been reimbursed less by a carrier serving their community. Among the 97 beneficiaries included in the 1986 SLC paid claims sample, 26 (27 percent) did not reside in the area serviced by the carrier paying the claim. The HCFA is currently reviewing the area of carrier claims jurisdiction.

Another carrier best practice involves reviews of beneficiaries' claims histories to determine whether the authorizing physician for the SLC has previously treated the beneficiary, a likely indicator that a course of treatment preceded the prescribing of the SLC.

RECOMMENDATIONS

1. *Coverage of SLCs*

In light of the strong evidence that SLCs appear to be used primarily as furniture, HCFA should reconsider whether SLCs, in fact, meet the Medicare definition of DME.

2. *Payment safeguards*

a) Immediate steps should be taken by HCFA to further improve the effectiveness of carrier processing of SLC claims. The HCFA should disseminate to its carriers the best practices identified in the inspection which help to assure that current coverage requirements for SLCs are met. These include having carriers review beneficiaries' claims histories to:

- determine whether the authorizing physician for the SLC had previously treated the beneficiary. This would indicate whether a course of treatment including a SLC was initiated prior to its authorization and delivery; and

- ascertain whether the beneficiary has a wheelchair or power-operated vehicle and, if so, whether the SLC should also be covered.

b) The HCFA should implement the OBRA 1987 provision of PL 100-203, section 1834, which prohibits payment for DME unless the supplier has received a written order from the physician before delivery of the item to the patient.

c) The HCFA should instruct carriers to develop and refer sanction recommendations to the OIG when carriers have identified physicians with patterns of unnecessarily prescribing SLCs.

d) The HCFA should direct carriers to enforce the provisions of the Medicare Carriers Manual section 5220 by allowing only those charges which the supplier expects to receive when they routinely waive collection of coinsurance and deductible payments. Suppliers found to have routinely advertised a general intention to waive such payments or to have failed to make reasonable collection efforts should be referred to the OIG for sanctions.

e) The HCFA should also instruct carriers to refer to OIG for civil money penalty cases in which suppliers advertise SLCs as being "Medicare-approved" or "endorsed" or "authorized" in violation of the Medicare Catastrophic Coverage Act of 1988;

f) The HCFA should expedite its review of the carrier jurisdiction issue and resolve the problem of out-of-service-area claims which denies carriers data essential to assuring the integrity of SLC and other claims.

APPENDIX

COMMENTS ON DRAFT REPORT

Comments received from the Administrator of Health Care Financing Administration indicate essential agreement with the findings. The HCFA reports it has begun a number of actions to implement the OIG recommendations, including:

- development of draft *Federal Register* notice that addresses coverage issues relating to SLCs (recommendation 1);

- disseminating best practices information to the carriers (recommendation 2a);

- preparing regulations to implement section 1834 of the Omnibus Budget Reconciliation Act of 1987. The regulations will include SLCs as one of the items for which the supplier must have received a physician's written order before the item is delivered to the patient (recommendation 2b);

- instructing carriers, effective for services rendered on or after January 1, 1989, to require that the suppliers have a written order in hand prior to delivery of the equipment to the beneficiary (recommendation 2b);

- instructing the carriers to conduct an indepth medical review of all SLC claims (recommendation 2c); and

- reviewing the issues of carriers jurisdiction in order to look at ways to resolve the problems of out-of-service area claims (recommendation 2f).

The HCFA also suggested that the OIG take vigorous action to curb abuses regarding SLCs noted in the report. We have expanded our recommendations to reflect such concerns expressed by HCFA and the OIG's Office of Investigations. However, before the OIG can act, cases must be referred to it by HCFA and its carriers through increased diligence in identifying instances of routine waiver of coinsurance and of suppliers who misuse the word "Medicare" in advertisements.

SEAT LIFT CHAIR DEMONSTRATION

Senator HARKIN. Thank you both. From your written testimony which I read over yesterday and from what both of you just said this morning it seems to me we have a lot of work to do this in area.

I will start off with you, Mr. Kusserow. Now, I have never seen this chair before. I was surprised, I thought from the description that I had heard, it was perhaps some kind of a medical device. This looks like a recliner to me. Is this one of the typical seat lift chairs, SLC's, as you call them?

Mr. KUSSEROW. That is very typical. It is something you might want to take home and watch TV on tonight. You do not have to use that motor. You can cut the cord off. It is still very useful. It is a nice piece of furniture.

Senator HARKIN. How does it work? What does it do?

Mr. KUSSEROW. It assists somebody to stand. Here is a gentleman who is slightly overweight. [Laughter.]

Senator HARKIN. Someone said it needs to be plugged in.

Mr. KUSSEROW. Unfortunately here for our chief inspector he does not qualify for Medicare payment for this device, but you can get mom or dad to ask for it and then they can give it to you.

Senator HARKIN. How does it work?

[Mr. Kusserow demonstrated how the chair works.]

Mr. KUSSEROW. It is not unlike the old Lazy Boy type of recliner. The other feature it has is that it will assist somebody who, in fact, is unable to stand on their own or does not have equilibrium to come out of a chair. It will help them stand up by providing, in fact, a seat lift, hence the name. This is the kind of device that I think every home in America should have, at least one. [Laughter.]

Senator HARKIN. How much does this chair cost?

Mr. KUSSEROW. This one would be about $870. This is on the low side of the spectrum. They can be much more expensive. They can be twice as much as this with essentially the same features.

Senator HARKIN. When you sit in it, you must move it back down again, right, you sit in it? I have never seen such a thing.

Mr. KUSSEROW. What we want you to do, Gene, is for you to demonstrate that you can stand up on your own. [Laughter.]

DEFINING DURABLE MEDICAL EQUIPMENT

Senator HARKIN. One of the principal findings of your report was this, you said that these seat lift chairs do not qualify as durable medical equipment under the Medicare program. How did you come to that conclusion?

Mr. KUSSEROW. Well, basically, the essential feature that would differentiate this device from the other types of devices is the fact that a durable medical equipment is supposed to be something that cannot be used for another purpose. I think we have already seen here that this could be used for another purpose. I do not think there is anybody in this room that could not find a use for something like this in their home. It is nothing more than a recliner that has the capability of being motivated by electricity and to do certain things, recline, help you out of the chair or sits you back down.

Senator HARKIN. Does it vibrate? [Laughter.]

Mr. KUSSEROW. I think we can probably find one that could, but the point is, Mr. Chairman, I think it does not take too much of an imagination to see that if you have somebody who is a geriatric in their home, somebody comes by and demonstrates this to them and says you can have one of these for nothing, that is fairly attractive and especially if they say you are entitled to it under Medicare. I do not think you have to watch too much television before you see ads which hint at that.

Senator HARKIN. How many of these have been marketed in the last few years through Medicare, do you have any idea how much we have spent for these?

Mr. KUSSEROW. Millions. I estimate that if we were just to cut back and put some more controls on the system and eliminate some of the abuse, you could have savings that would range from somewhere between $30 and $60 million.

Senator HARKIN. You said that in your testimony, I wrote that down. Between $30 and $60 million savings over what period of time?

Mr. KUSSEROW. Annually.

Senator HARKIN. Annually?

Mr. KUSSEROW. Yes, sir.

Senator HARKIN. You are saying we are spending about that much on these chairs right now?

Mr. KUSSEROW. Yes, sir, more.

ABUSING THE SYSTEM

Senator HARKIN. How do they market them? What do they do?

Mr. KUSSEROW. There is a whole wide range of marketing. First of all you start off by saying that it is easy, that someone who is elderly might, in fact, find this to be an attractive device and they can be convinced that they were entitled to it. So, the trick is, how do you find the elderly? In the one case I gave you in my testimony is that somebody bought a list of phone numbers of people over 65, but you could go to a nursing home or where elderly congregate and you could accomplish the same thing.

Senator HARKIN. Demonstrate the chair?

Mr. KUSSEROW. Demonstrate the chair and if you want to misrepresent it, you can misrepresent it and say that, indeed, that anybody is entitled to it. Medicare will pay for it.

Senator HARKIN. The thing is, with the Medicare recipient, would they not have to get a doctor's approval before?

Mr. KUSSEROW. Normally how it works, Mr. Chairman, is that where you do have, and understand there is nothing wrong with this chair, and in fact it can be used to good advantage for somebody who would have trouble standing, would not have equilibrium, would need assistance, so it is not a bad device.

The point is that the way that we find that you have suppliers abusing the system is that they go in and misrepresent the product. They will go in and say that this is something that Medicare is willing to give you because you are elderly and it will help you and see all of the wonderful things that it can do and you can see that people would say, yes, that is nice, I would not mind having one in

my home. The person who would be in control of the process would be the supplier. The supplier would first get the patient and then get the physician to sign off on it.

Senator HARKIN. Stop right there. The physician has to sign off on this?

Mr. KUSSEROW. Yes.

Senator HARKIN. You mean to say there are doctors signing off on $30 to $60 million of these every year?

Mr. KUSSEROW. That is correct.

Senator HARKIN. Why would a doctor do something like that?

Mr. KUSSEROW. Well, the doctor might do it, because, it may in fact be of assistance to the patient. The doctor might do it because they may be on the payroll of the supplier. The doctor may do it, remember in my testimony I mentioned another feature that would be in this one case where the physicians were being intimidated. They say, the patient wants this, your patient wants this. If you deny it to them, we can make trouble for you. So there is some intimidation.

Senator HARKIN. What do you mean by that?

Mr. KUSSEROW. Well, they would be threatening the physician that they might get sued or lose the patients.

Senator HARKIN. Or if a doctor had a patient and the patient came and sat in one of those chairs and the doctor said you do not need it, the patient might find another doctor.

Mr. KUSSEROW. I think what we found in that one case is the supplier actually encouraged the doctor to that thinking. Actually it was not even the doctor coming to the patient, it was the supplier going to the physician and saying, here, this is your patient, they told us that you were the doctor, this is what we can give them and you have to sign here and if you do not, we will go back and tell them that you refuse to give them this machine which is free.

Senator HARKIN. Is this the one that was indicted?

Mr. KUSSEROW. Yes.

Senator HARKIN. Is that a recent indictment?

Mr. KUSSEROW. Yes.

Senator HARKIN. That is the activity that they were engaged in?

Mr. KUSSEROW. What is interesting, if you look at the payment for these devices they can range enormously because once you crack down on it, you can almost go, as we have in the one case that we are documenting in our audit findings, go from $7 million down to $10,000 a year just by putting good controls in the system.

What we have found is we went around the country and if you track the history of the cost of these devices, you will see there is a lot of undulation in there and that is because of the facts where we crack down it goes down but they pop out some place else.

One of the other things that we find that we think that we should try to cure and that is the payments should be made basically where they are selling the products and not where they find a convenient contractor. We found cases where suppliers would go, in effect, forum shopping. They would go look to find out who is a good medicare contractor in terms of letting them bill without questioning. And then they would put up a front there and have the bills come from that location to avoid another contractor who

would be more restrictive and have more controls on paying the bills. Once again I think what that underscores is the real importance of the contractors being our first line of defense in these abusive and fraudulent practices.

DEFINING AND REFERRING FRAUD CASES

Senator HARKIN. Let me go from the specific to a more general aspect. I am particularly interested in the cases of fraud, which evidently this was if there is an indictment.

Mr. KUSSEROW. We have quite a few cases that have crossed that threshold from being merely abusive to being fraudulent.

Senator HARKIN. But you said that only 6 percent of the cases, and I assume the cases referred to earlier.

Mr. KUSSEROW. The referrals. As I mentioned in my testimony, Mr. Chairman, the contractors will refer suspected cases of abuse or fraud to us. We have a real definitional problem in the sense of, let us take a hypothetical where you might be a contractor and you find a physician that may have been submitting or a supplier that submitted 12 or 15 different bills.

Now, you can submit that as a single referral. That is the way we would look at it, as a single referral, or you might take each one of the questioned billings as a separate case or a separate referral and, therefore, you would have 12 or 15 referrals. So a lot of it is how far has the contractor developed it and how much of a package do they have.

But again, we would be underestimating the value of the contractors if we only talked about what percentage of the cases they refer to as actually resulting in successful actions because we have a tremendous number of cases we develop on our own and in every case we really have to turn to these contractors for assistance to give us the documentation to support our prosecutions, whether they be of a criminal or civil or administrative nature. So referral is only one aspect of the support we look to the contractors for.

Senator HARKIN. Where do most of your initial leads come from?

Mr. KUSSEROW. Most of them come directly to us from the public through our hotlines.

Senator HARKIN. How did you find out about the chair?

Mr. KUSSEROW. In this particular case I had referred to in my testimony, it came from a Member of Congress, Mr. Horton on the House side. I referred the matter to him and it came through a constituent. When we looked into it, it turned out to be a very good case and for that we are thankful to Mr. Horton.

Senator HARKIN. So most of your leads come from sources other than the Medicare contracts.

Mr. KUSSEROW. There are a lot of elderly folks that when somebody comes by, they get suspicious when somebody says you get something for nothing. Oftentimes they are the ones that will call. Sometimes a physician will call and say, wait a second, I had somebody come by here intimidating me, trying to get me to sign off on a prescription that, in fact, is not warranted. So we get it from physicians as well.

It is not just the beneficiary patient community but sometimes the practitioner community. Other times it is durable medical

equipment suppliers. They look around and they see there are unfair trade practices going on among their competitors and they will blow the whistle, if you will.

So we have a wide variety of referrals. Those referrals can be made directly to us or sometimes they will go to the contractors and be referred to us. There are a wide variety of sources for this information.

CONVICTIONS AND SETTLEMENTS

Senator HARKIN. You said that 6 percent, about 6 percent of the contract referrals resulted in criminal convictions and civil settlements. Does that include administrative sanctions?

Mr. KUSSEROW. Yes.

Senator HARKIN. So only 6 percent involved anything from administrative sanctions all of the way through convictions.

Mr. KUSSEROW. That is correct. That comes out on an average of about 32, 30, 32, 34 a year. That is, on the other side of that equation, the number of criminal convictions that we have in our office each year is over 1,200 and the number of additional civil and administrative prosecutions is another 500, but that covers the entire Department.

Senator HARKIN. This is just a small part of it. You say how many here.

Mr. KUSSEROW. The Health Care Financing Administration is only 12 percent of the outlays of the Federal Government. That is a small part of our Department. So you have an idea that we have a lot of, it is a big department.

Senator HARKIN. Why are you not getting more from contractors? What can be done to improve both the number and quality of the cases referred to you by contractors?

Mr. KUSSEROW. I think we have to say this is important. I do not think we say safeguards are important if we are going to cut that portion of the contractor's budget that relates to safeguards by $135 million. The message to me, if I was a contractor, was that that is not very important. That is No. 1. No. 2 is in rating contractor performance I think that instead of being eighth or ninth in terms of importance in the rating criteria you should be closer to the top.

RATING CONTRACTOR PERFORMANCE

Senator HARKIN. I want to ask you about that. Just a second.

You said that, let me get my notes here, 10 percent of the contractors you rated as very good. Two-thirds you said average, one-fourth very poor. Some contractors did not refer much that was actionable. However, under HCFA's rating of the contractors, the worst one got a 90-percent rating.

Mr. KUSSEROW. They were rating the entire spectrum. There are 10 different criteria for rating their performance. That is my point, Mr. Chairman, that is in terms of the 10 elements that go into rating a contractors performance.

Senator HARKIN. Just a second, Mr. Kusserow, if I may interrupt. Counsel tells me that 30 percent of the weight of the performance evaluations go to the safeguard activities of a part A contrac-

tor. Thirty percent, and yet the lowest one in HCFA's rating got a 90-percent rating overall. I do not understand that.

Mr. KUSSEROW. Fraud and abuse out of 1,000 points, that portion is 70 points. You can put that together with other types of elements, like medical review and medical utilization.

Senator HARKIN. I understand. You said out of 1,000 points.

Mr. KUSSEROW. Out of 1,000 points, 70 relate to fraud and abuse. There are other safeguard elements that add to that, but fraud and abuse is only 70 out of 1,000.

Senator HARKIN. Wait a second. The guide I have here, 1,000 points and 100 goes to audit, 125 to medical review, and 80 to secondary payer activities. That adds up to 305 out of 1,000.

Mr. KUSSEROW. The fraud abuse component of that whole thing is 70 points.

Senator HARKIN. The what?

Mr. KUSSEROW. The fraud and abuse safeguard is 70 points.

Senator HARKIN. If we add that in, that is 375. I am just talking about the number of cases you say are referred.

Mr. KUSSEROW. That comes as a result of their fraud and abuse activity.

Senator HARKIN. Not because of the other activities.

Mr. KUSSEROW. No; you can have, for example, on the audit side that they could be, the questioning of payments but it does not necessarily mean that it is fraud.

Senator HARKIN. It could be an honest mistake or something like that?

Mr. KUSSEROW. Right. A significant number of cases that are referred to us for investigation are mistaken and we do not prosecute people for making an honest mistake.

Senator HARKIN. Are you telling me that you think the fraud and abuse points ought to be higher than that in the evaluation?

Mr. KUSSEROW. What I am suggesting, Mr. Chairman, is if you have that as ranking 8th out of 10 in terms of points and at the same time that we are cutting that very substantially, it just seems to me that the accent clearly is not on the safeguard arena. It is the whole area of the audit activity as well as the fraud and abuse activity. I do not think that is indicative of the fact that you are putting proper weight to it. If somebody——

Senator HARKIN. So your answer is yes, it ought to be higher?

Mr. KUSSEROW. If you and the appropriations process were to cut my budget by 50 percent, I think I would get a message that you probably did not think we were as important as we thought.

Senator HARKIN. Of course that budget cutting comes from the other three areas, too. It is not just fraud and abuse, it covers everything.

Mr. KUSSEROW. That is correct. And then you are talking about the Inspector General who wears many hats. One is a fraud and abuse hat and the other is the auditor's hat. I am here to say that if you were to cut our audit budget by 50 percent you would have my attention as well. I would read that as a message.

IMPROVING CONTRACTOR PERFORMANCE

Senator HARKIN. Well, I asked you what could be done to improve both the number and quality of cases referred to you by the contractors. You focused in on the points and system.

Mr. KUSSEROW. There are other things that I think we need to do, and part of it is our responsibility. We have to, as we have been, work with the contractors and let them understand what it is that we need in order to take proper action. At the same time, I think we have to encourage them that that is a very important part of their job and that they should look for these. We find that in many cases they encounter fraud and abuse and usually it is because they do not recognize it or they do not think it is important and they do not refer it. They really need to refer it.

EFFECTS OF CUTTING PAYMENT SAFEGUARD ACTIVITIES

Senator HARKIN. I think this subcommittee ought to look at that point system and we will ask HCFA why they do not have higher points than that.

Just for the record, Mr. Kusserow, you have stated before but again I just want to make it very clear. You believe that the cut proposed in the budget for payment safeguard activities will result in losses to the trust funds and that fewer cases of fraud and abuse would be detected?

Mr. KUSSEROW. Yes, sir.

Senator HARKIN. Mr. Zimmerman, back to GAO. Again, I will ask you the same question I just asked Mr. Kusserow. Do you believe that this budget cut would result in less claims or information being filed as to fraud and abuse cases?

Mr. ZIMMERMAN. Well, it certainly could have an effect on that. I think, more directly though, there is a little uncertainty, in fact, on the program costs, because as we pointed out in our statement, and I think the administration has as well, that there is a return of at least $8 of $1 spent, so I would think a cut of that magnitude would have a significant effect on program cost.

Senator HARKIN. Let me ask you this and it has to do with your chart up there about Medicare savings from payment safeguards. What you indicate from that graph is that at least going back to 1986, substantial savings, I forget what your testimony said exactly.

Mr. ZIMMERMAN. I think I indicated they averaged about $3.25 billion a year starting in 1986. We do use estimated figures and we do not make a distinction on the chart for 1989 and 1990, but as you can see, the shaded area is closing in and I think that reflects the administration's proposal to go with a lesser safeguard amount and, thus, lesser safeguard savings, something in the neighborhood I think of $2 billion.

CUTS IN SAFEGUARDS INCREASE MEDICARE COSTS

Senator HARKIN. Again, as you know, most of the funding included in the Medicare trust fund comes from payments made by the elderly and $35 billion comes from appropriated dollars. To the extent that Medicare costs go up because of reduced payment safe-

guard activities, is there a likelihood that this would result in an increase in premium payments by the elderly?

Mr. ZIMMERMAN. There certainly is a potential for that, particularly over time. If there is a cutback in safeguards, that means there is going to be, at least in my opinion, an increase in program costs. Part B is the part that is funded to a large degree by general revenues, but the beneficiaries pay as well, and to the extent that part B costs will go up without the safeguard funding, then ultimately the beneficiary would have to pay.

Senator HARKIN. In other words, it is not just saving taxpayers dollars, it is protecting the elderly from having to pay higher premiums some years down the pike.

Mr. KUSSEROW. Most certainly. With the advent of catastrophic, which is funded pretty much by the elderly, it will have a definite impact in that area as well.

Senator HARKIN. With the new program covering drugs and everything else, we might even want to, again, this is going to be another new area in which we will have to have the contractors involved in the fraud and abuse cases.

Mr. ZIMMERMAN. Most certainly. It is a major expansion of the program. The budget does call for, I think, $128 million to help fund certain aspects of the catastrophic provision, but attention will have to be paid in that area as well as the other parts of the program.

I might also add that when Medicare physicians' costs go up, the copayment is paid by the beneficiary so the bulk of it is picked up by the program but there is always a direct payment by the beneficiary for the copayment which is 20 percent of the Medicare allowable charge.

Senator HARKIN. Let me direct your attention to the second graph over there, the chart. I want to clear up something here. When I was looking at this last night I looked at the payment safeguard costs and program savings. Well, we did not have cuts in these years. But if you look from 1988 to 1989, the payment safeguard costs went up slightly but the program savings came down. Now, what you are indicating from 1989 to 1990 is because of the cut we will have a drop here. How come we had a drop here even though we did not have a cut here?

Mr. ZIMMERMAN. I think first off, the 1988 figure represents some $1.1 billion in savings that were achieved as a result of audits conducted in prior years, so your 1988 savings figure is somewhat higher for that reason. But, I also think the 1988 figure is higher than the 1987 and 1986 figures because Medicare secondary payer activities have increased substantially, and I think that it is starting to have an impact. The 1989 figure is still an estimate. I think there may be some significant amounts of funds still out there that have not been accounted for.

And, of course, 1990 represents a situation where we know there has been a substantial cut in the safeguard costs and also the anticipated savings.

Senator HARKIN. We will try it again. The safeguard costs went up from 1988 to 1989, but the program savings were reduced. You are telling me from this point on that if you cut it, if you cut the

program safeguard costs you cut the savings, what we say about an 8 to 1 factor but that certainly did not happen here.

Mr. DOWDAL. Mr. Chairman, the last numbers on the chart that are actuals are those in 1988; 1989 is strictly an estimate. I do not know why they reduced their estimate for savings in that year. I think the reason that 1988 went up a lot higher than the prior years is because they have started to get a lot more savings from the third-party coverage program.

Senator HARKIN. You mean in here?

Mr. DOWDAL. Right. You will have to ask HCFA why they are estimating a much lower savings ratio for 1989 than what was achieved in 1988.

Senator HARKIN. Well, we just found out. Here is the answer. It is a footnote in the budget justification. From audit activities an additional $1.1 billion in savings were achieved in fiscal year 1988 from settlement of audits from fiscal year 1987 and prior years. So what the 1988 figure shows is just settlement of those things that went on before. You say no?

Mr. DOWDAL. I do not think that that is included in that number.

Senator HARKIN. Pardon?

Mr. DOWDAL. I do not believe that $1.1 billion is included in that chart because of the consistency basis that it is not in the subsequent years.

Senator HARKIN. We will get it cleaned up.

Mr. DOWDAL. One big change in that budget is if we look at the audit they are expecting only $59 million in savings from the audit and I do not understand why it would drop from $800 million to $60 million in 1 year.

Senator HARKIN. I will find out.

SANCTIONS AGAINST CONTRACTORS

I want to ask about sanctions. Mr. Zimmerman or Mr. Kusserow, I will throw out a question. I have written it down in one of your testimonies. What kind of sanctions are there that accrue to a contractor who does not really report fraudulent cases. What kind of sanctions are there out there?

Mr. KUSSEROW. The ultimate sanction is that it will affect the renewal of their contract and it will not be renewed.

Senator HARKIN. The renewal of their contract is based upon a point system.

Mr. KUSSEROW. Yes; but any area where it is nonperformance, if it is severe enough.

Senator HARKIN. Let me read from your testimony. You said: In addition, our investigations of certain referrals have shown that contractor personnel were aware through beneficiary complaints and claims review activities that fraud or abuse was occurring but took no action to identify or stop it. We have identified instances in which contractor personnel have known that a claim was altered. They continued to pay the claim and did not notify the OIG.

What do you do about that?

Mr. KUSSEROW. You have a choice. You do not even have a choice between a traffic ticket or a nuke. You basically stand, you have to educate them and convince them that they should do that.

Senator HARKIN. How much education does it take to tell someone that they should identify fraud? I can understand honest mistakes that are made.

Mr. KUSSEROW. I agree. And hence the frustration that we have, if education does not work and they still thumb their nose and are being paid to do that performing, well their choice is that they have it affect their contract and what we are finding is that that is an inadequate range, in that range is inadequate ability to police the contracts.

Senator HARKIN. If you have a contract that had a claim that was altered, continued to pay it and did not notify you, you say there is really nothing you can do but go out and say, look, you should not do that.

Mr. KUSSEROW. And bring it to the Health Care Financing Administration's attention that we have a contractor that is not really fulfilling the contractual obligations in doing that.

Mr. ZIMMERMAN. Mr. Chairman, I think basically all you can do is terminate the contract. There is nothing in between. I think that Mr. Kusserow is saying a traffic ticket or a nuclear bomb is no real choice.

Senator HARKIN. There are no fines, or there is nothing else that you can do?

Mr. KUSSEROW. I would welcome something in between.

Senator HARKIN. Maybe that is what we ought to be looking at, something else in between. It appears we need other sanctions alternatives, in addition to the rating system.

Mr. ZIMMERMAN. They have cut contractors off but I would suspect not for that reason.

Senator HARKIN. Not for that reason.

Mr. KUSSEROW. Well, then you could convince me on that reason that some should be, yes.

Senator HARKIN. Convince me, too. That is what I am concerned about. There are no real sanctions for the contractors to really ferret out fraud and abuse and report it, and it just seems like we are always going to have a tough time in litigating these cases.

Mr. KUSSEROW. You are going to get a lot of testimony from HCFA later about the fact that there is an enormous range in performance in the safeguards arena. And the question is how can we bring everybody up to a higher standard and not have people that are on the low end and that may be a fruitful area for further consideration.

Mr. DOWDAL. Mr. Chairman, we have recommended on a number of occasions that the standards that HCFA uses to measure contractor performance be increased. We specifically made one recently in the area of MSP in that area, so by making what they have to meet to pass the evaluations tougher, then you have a better chance of getting better performance.

Mr. KUSSEROW. That is precisely what I was saying earlier. That is, there are a lot of ways to get at the problem. One is to raise the weight of performance evaluation on the safeguards arena, but you cannot do that if you are going to be cutting the budget by 50 percent.

Mr. ZIMMERMAN. Another thing is, of course, making the contract provisions more challenging than what they are now in some

of these areas and, of course, we have recommended that that be done.

Senator HARKIN. I am sorry.

Mr. ZIMMERMAN. Another thing would be to make the contract provisions in some of these areas more challenging, particularly in the MSP area, we felt that it did not take very much for the contractor to meet the requirements of the contract and the Government was losing out on its opportunity to prevent payments from being made that were unnecessary so we recommended that they put more of a challenge into the contract provisions.

We found out in our work that the contractors were meeting these provisions very quickly and then shifting resources or their attention to some other areas in the contract where they were not doing so well. Even so the program was losing its opportunity to recover savings because of the shift in resources.

Senator HARKIN. Thank you all very much for your testimony today, for preparing the record, for bringing this up here for me to see. I honestly thought that it really was a medical device because as, you know, I chair the Handicapped Subcommittee and there are devices for truly handicapped individuals to use to get them in an upright position. Usually a wheelchair first to get them upright for certain periods of the day for something and things like that which cannot be used for anything else. That is what I thought we were talking about.

Mr. KUSSEROW. This could be, it seems to me, Mr. Chairman, be very handy for you when you are conducting your hearings and when you give a hint to somebody that it is time to leave you could just sort of remotely press a button and they would be gone. [Laughter.]

Senator HARKIN. Do you think I can get Medicare to pay for that? [Laughter.]

Thank you all very much.

STATEMENTS OF:

BILL HORTON, VICE PRESIDENT OF MEDICARE OPERATIONS, BLUE CROSS/BLUE SHIELD OF SOUTH CAROLINA

ARTHUR LIFSON, VICE PRESIDENT, EQUICOR

SALLY WOOD, VICE PRESIDENT OF GOVERNMENTAL AFFAIRS, BLUE CROSS/BLUE SHIELD OF IOWA

Senator HARKIN. I would like to call our next panel, Bill Horton, vice president of Medicare operations, Blue Cross/Blue Shield of South Carolina, Arthur Lifson, vice president of Equicor and Sally Wood, vice president of governmental affairs, Blue Cross/Blue Shield of Iowa.

We will start with Mr. Bill Horton, vice president of Medicare operations, Blue Cross/Blue Shield of South Carolina and then we will go to Arthur Lifson and Sally Wood.

Let me say that I do appreciate your coming here today and submitting your testimony beforehand. I had a chance to read it yesterday. Your statements will be made a part of the record. If you can summarize them in 5 or 10 minutes, that would be very appreciated.

Mr. HORTON. Thank you Mr. Chairman. I am Bill Horton, vice president for Medicare operations of Blue Cross and Blue Shield of South Carolina and I am here today to share my opinions on the impact of proposed cuts in payment safeguard activities for Medicare contracts.

Blue Cross and Blue Shield of South Carolina commends the chairman for your interest in protecting the Medicare beneficiaries of this country and the Medicare trust funds from inappropriate expenditures. I would like to tell you just a little bit about Blue Cross and Blue Shield of South Carolina.

We have been a Medicare contractor since the inception of the Medicare program in 1966. This year we will process nearly 6.2 million individual claims for Medicare services for beneficiaries in South Carolina, for physicians, hospitals, and other health care providers. We will pay about $1.4 billion in Medicare benefits through our operations. That is a rate of about $700,000 per hour, Mr. Chairman, so the program is certainly large with a great deal of room for potentially erroneous payments. We will also respond to about 500,000 inquiries from Medicare beneficiaries in our State.

Perhaps the most remarkable accomplishment of Blue Cross and Blue Shield of South Carolina, and I wish to suggest of other contractors around the country, is the record of documented tangible savings achieved over the 20 plus years of the Medicare program in the area of payment safeguards.

In our case, we saved over the last year for the trust funds, Mr. Chairman, about $84 million. Put another way, for each dollar that we expended in administrative costs, we returned $17 to the program. That is a pretty good rate of return, I think, slightly higher than the national average but the national average is very good, 8, 9 to 1. Nationally, $3.1 billion in unnecessary or inappropriate payments were avoided last year.

Ironically, at least to me, is that these savings, as I understand it, are not considered an annual Federal budget development process. I do not believe any credit is given or the savings cannot be scored against the outlay targets that the Congress and the administration attempt to meet. Rather, only the relatively small dollars that the contractors spend to achieve these savings are subject to budget reductions.

This seems to me to be a dichotomy that could very well lead to a clearly irrational budget decision, that being the supposed savings of about $134 million in contractor costs at an actual cost to the Federal Treasury of over $1 billion in lost savings. I would suggest to you, Mr. Chairman, that if there were some way to score these savings that contractors achieve against the outlay targets, that perhaps the cuts proposed by the administration would not be necessary.

Mr. Chairman, you asked that we provide you with specific examples of fraud, waste, mismanagement that we as individual contractors have encountered in carrying out our payment safeguards duties. I have included in my written statement several such examples and in the interest of time I will simply summarize one for you here today. It is one of the examples that you refer to in your opening statement, Mr. Chairman.

PAYMENT SAFEGUARD: AUDIT FUNCTIONS

One of the three major payment safeguard functions is called provider audit or audit. The purpose of this activity is to ensure the integrity of the annual Medicare cost reports that are filed by hospitals, filed by skilled nursing facilities, and filed by home health agencies. These cost reports represent the final all inclusive claim to the Federal Government for reimbursement for all of the services those facilities rendered to Medicare patients in a given year.

The audit function at a contractor typically results in an on-site review by highly skilled professional accountants who go out to the site of the facility and review the records and the books and the accounts to ensure that the cost report is filled out properly. At Blue Cross and Blue Shield of South Carolina we employ 50 of these auditors in this activity.

One hospital in South Carolina recently, Mr. Chairman, claimed on its annual Medicare cost report, asked for Medicare to pay for the costs it incurred to establish and operate a private health club on two vacant floors in that hospital. Solely as a result of our on-site audit of this hospital did we discover the existence of this health club and make the appropriate changes to the cost report to avoid about $370,000 in inappropriate program expenditures.

Now, this particular hospital did feel that it was entitled to some payment from Medicare because this health club was used occasionally by its physical therapy department to treat patients of the hospital, but certainly not to the extent that it was included on the report submitted to us.

Many such opportunities for program savings, many mistakes, occasionally fraud, frequently simply a lack of understanding of the complex Medicare regulations and policies, come across the desks of the audit staffs of the Medicare contractors. We in South Carolina returned on this function alone about $15 for each $1 that we expended last year.

We understand that the administration's fiscal 1990 proposal for contractor payment safeguard funding would totally eliminate the on-site audit activity for all Medicare contractors. We would suggest that at least in the private sector, given the return these activities generate, that it might not be a sound management decision, and in fact what we believe will occur, the auditors that will either be laid off from the contractor sites or choose to leave instead of waiting to be terminated. Many of these will, in fact, go to work for the very hospitals and nursing homes that they have audited in the past and will serve in a capacity that will attempt to maximize the amount of money the hospitals and nursing homes receive for Medicare. So there may be a double hit if, in fact, the audit fund is reduced.

MEDICARE GROWTH

In closing, Mr. Chairman, I would like to mention that, as you know, and as you can see from the chart on the left here, Medicare spending has grown at a very rapid pace. In fact, from 1980 to 1988, I believe it increased from 1 percent of the GNP of this country to about 1.6 percent today and it continues to grow at two to

three times the general inflation rate. For your Medicare constituents this does, in fact, translate into higher copayments, higher premiums, potentially higher deductibles, especially when the catastrophic insurance program is fully implemented.

It is obvious that when Medicare expenditures grow at a disproportionate rate to other Federal expenditures that the other priorities of the Federal Government are difficult or impossible to meet. I am sure you know and I believe that there are no simple solutions to this rapid growth in Medicare's spending or health care costs in general, but I certainly do not believe that reduction in funding for Medicare payment safeguards would be a solution.

Instead, such reductions would lead to an acceleration in Medicare spending as contractor oversight of the trust fund payments declined. I would, therefore, urge you to maintain the sound investment you and your colleagues and the administration have made in past years in these vital areas and reject the shortsighted cuts the administration has proposed in its fiscal 1990 budget.

Very briefly, I would also urge the chairman and the subcommittee be mindful of the need for adequate payment for the other activities performed by Medicare contractors other than payment safeguards. To ensure the continued accurate and timely processing of claims, the timely response to inquiries from your constituents as well as the Medicare providers, stable funding needs to be maintained for these activities as well.

PREPARED STATEMENT

We will already require some additional funding to implement the new conditions of the Medicare Catastrophic Coverage Act of 1988. The National Blue Cross and Blue Shield Association has requested the opportunity to testify more specifically on these specific funding needs later in your hearings on the HHS budget.

Mr. Chairman, that concludes my oral remarks and I thank you for the opportunity for sharing my views with you today.

[The statement follows:]

STATEMENT OF WILLIAM R. HORTON, JR.

Mr. Chairman and members of the subcommittee, I am William R. Horton, Jr., Vice President of Medicare Operations for Blue Cross and Blue Shield of South Carolina. I have been responsible for various Medicare contractor functions for Blue Cross and Blue Shield of South Carolina since 1974. From 1974 to 1985, I first performed and later managed audits of hospital, skilled nursing facility, and home health agency cost reports -- a payment safeguard function. Since 1985, I have directed all Medicare intermediary and carrier operations for Blue Cross and Blue Shield of South Carolina.

An intermediary is a Medicare contractor responsible for making payments to facilities, primarily hospitals, for services rendered to Medicare beneficiaries. Payments to physicians for their services are made by Medicare contractors called carriers. Carriers also make payments directly to Medicare beneficiaries if their physician declines to accept Medicare's payment (i.e., assignment).

The State of South Carolina, with a population of 3,424,000, is predominately rural with several high tech, urban centers - including two of the twenty fastest growing (business and industry) metropolitan areas in the United States. The South Carolina coast, especially Myrtle Beach, Charleston, and Hilton Head Island are favorite destinations for tourists. The health care delivery system in the State is extremely diverse: ranging from small, 20-bed community hospitals to 800-bed tertiary care centers. We have a mix of government, private, proprietary and church-sponsored hospitals. There are two medical schools in South Carolina and several teaching hospitals which provide large amounts of care to indigent South Carolinians. About 400,000 Medicare beneficiaries reside in the State.

Since the inception of the Medicare Program, Blue Cross and Blue Shield of South Carolina has served as both a fiscal intermediary and a carrier responsible for administration of the Medicare Program in South Carolina. Additionally, Blue Cross and Blue Shield of South Carolina is one of nine regional home health agency intermediaries. We are responsible for making accurate and timely Part A payments to most home health agencies in Tennessee, North Carolina, Kentucky and South Carolina. Blue Cross and Blue Shield of South Carolina is one of two national carriers responsible for accurate and timely Part B payment for parenteral and enteral nutrition and immunosuppressive drug claims -- serving all suppliers and beneficiaries in the eastern half of the United States.

In fiscal year 1989, Blue Cross and Blue Shield of South Carolina will process about 6.2 million claims and pay about $1.4 billion in Medicare benefits to health care providers and beneficiaries. Our Medicare claims processing, payment safeguards, and ancillary activities will be carried out by a staff of approximately 650 employees. Blue Cross and Blue Shield of South Carolina will expend about $22 million to carry out its contractual responsibilities to the Health Care Financing Administration.

I am here today to testify on the importance of adequate and stable Medicare contractor funding for payment safeguard activities. Of equal importance, though not the subject of this hearing, is the need for sufficient funding for Medicare contractor services to beneficiaries and providers. If we are to continue timely payment of claims along with accurate and timely responses to inquiries from Medicare beneficiaries, sufficient funding for these activities is necessary. Contractors will also require adequate funding to implement the many new provisions of the Medicare Catastrophic Coverage Act of 1988. Our national association has

asked to testify before this subcommittee more specifically on these funding needs later in your hearings on the HHS budget.

Few, if any, government expenditures produce the documented, tangible savings of taxpayers' dollars generated by Medicare payment safeguard activities. Nationally, in fiscal year 1988, Medicare contractors expended about $305 million for payment safeguard activities or 21% of the total contractor administrative costs. These activities produced savings to the trust funds of $3.1 billion or 3.6% of the total benefit payout. The government's investment in payment safeguard activities produced a return of approximately $10 for each dollar expended. At Blue Cross and Blue Shield of South Carolina, we expended $4.9 million for payment safeguard activities or 29% of our total administrative costs. Our savings were $84.4 million or 7.7% of our benefit payout. We achieved a return of $17 for each dollar expended.

These are hard savings of Medicare Trust Fund dollars by anyone's definition. We and HCFA have management information systems that accumulate and report these data on a monthly basis. The savings are subject to verification by outside auditors at least once each year. Recently completed national audits by independent CPA firms found less than a 1% error rate in over $500 million of contractor-reported savings.

The myriad payment safeguard activities necessary to protect the fiscal integrity and solvency of the Medicare trust funds are generally grouped into three major functional areas:

- Medical and Utilization Review
- Audit (intermediary function only)
- Medicare Secondary Payer

My testimony will address each area individually and will provide a general explanation of the function, savings and administrative cost data for Blue Cross and Blue Shield of South Carolina, specific examples of savings, and an assessment of the probable impact of the Administration's proposed cuts in payment safeguards funding.

MEDICAL AND UTILIZATION REVIEW

Intermediaries and carriers are responsible for assuring that services provided to Medicare beneficiaries are medically necessary and covered by the Medicare Program. For example, more than one physician visit per week to a patient in a skilled nursing facility would not be considered medically necessary absent documentation explaining the medical condition or symptoms warranting the extra visit(s). Detecting and examining claims that exceed such limits without valid justification is the essence of this payment safeguard function.

Major activities include:

- Prepayment review of claims that, based on national and local "screens" (e.g., more than the normal number of physician office visits in a month), may not be medically necessary.
- Postpayment audits of providers whose claims, over the course of a year, indicate potential patterns of over utilization, fraud, or abuse when compared to peer group "norms."
- Education of providers on issues of coverage, billing practices, and expected patterns of care.

Blue Cross and Blue Shield of South Carolina's medical and utilization review activities are carried out by a staff of slightly more than 100. This staff is comprised of clerical personnel who have received basic coverage and medical policy

training, licensed practical nurses and registered nurses who conduct most of the "hands on" review, and management and support staff. A practicing physician, specializing in internal medicine, serves as the Medicare Medical Director. He is responsible for recommending and approving new medical review policies and acting as a liaison with the provider community. We also utilize an extensive physician consulting network to review claims in specific medical specialties and to assist in medical review policy development.

In fiscal year 1988, Blue Cross and Blue Shield of South Carolina's intermediary and carrier medical review activities generated savings to the Medicare trust funds of $19.6 million. Our administrative costs were $2.5 million. $12.75 was saved for each $1.00 spent on medical and utilization review activities. In addition to producing documented, quantifiable savings, medical review activity also saves a large amount of benefit payments through the deterrent effect of providers knowing the claims will be subject to review. This deterrent effect, coupled with the review findings, also serves to lower beneficiary liability for overbilled or inappropriate services. The reduction of medical review activity would without doubt result in providers rendering and billing the Medicare Program and beneficiaries for more services, resulting in increased benefit payout.

The subcommittee asked me to provide specific examples of our payment safeguard activities. In the area of medical review, one of the recent postpayment reviews conducted by Blue Cross and Blue Shield of South Carolina's carrier medical review unit addressed potentially unnecessary pre-operative eye examinations prior to cataract surgery. Normally, only one comprehensive eye examination and one special eye examination are necessary prior to cataract surgery. Our patterns of practice peer group analyses for ophthalmologists in South Carolina revealed six physicians whose

pre-operative examination services appeared excessive. Following an audit of numerous patients' medical records and discussions with the physicians, $61 thousand was refunded to the Medicare Program. These physicians had been performing pre-operative tests for both eyes although cataract surgery was only to be performed on one eye. These physicians have since changed their practice patterns, yielding ongoing savings to the Medicare Program.

Many hospitals in South Carolina have begun "air ambulance" (helicopter) services in recent years. Because of the high cost of these services, Blue Cross and Blue Shield of South Carolina's intermediary medical review unit performs prepayment medical review of most air ambulance claims. The Medicare Program pays for air ambulance transportation only when ground transportation is unavailable or when the patient's medical condition necessitates extremely rapid transportation to a hospital (e.g., heart attack, serious automobile accident, etc.) As with other very high cost technologies, hospitals have economic incentives to maximize the use of their air ambulances -- often when less expensive ground transportation is safe and available. A recent example included a patient transferred from Hilton Head Island, South Carolina to Columbia, South Carolina, a distance of about 150 miles. The patient had been admitted to the local hospital on Hilton Head Island after suffering a hip fracture. The next day the patient was experiencing no complications and vital signs were normal yet he was transported by helicopter to Columbia. Transportation via available, fully equipped ground ambulance would have been more "reasonable" for this patient. Medicare payment was reduced from $2,100 (air rate) to $700 (ground rate) - saving the Medicare Program $1,120 and the beneficiary $280. Blue Cross and Blue Shield of South Carolina saved the Medicare Program nearly $600 thousand in 1988 by reviewing air ambulance claims and reducing payment to ground transportation rates where medical justification for the more expensive service did not exist.

The Health Care Financing Administration in its FY 1990 budget justification projects a reduction in medical and utilization review savings of $244.6 million if the Medicare contractor funding for this payment safeguard activity is reduced by 30% as proposed by the Administration. I believe that Blue Cross and Blue Shield of South Carolina's savings would be reduced by $5.00 - $10.00 for each $1.00 reduction in our medical and utilization review funding. A 30% reduction would also materially impact our ability to continue our current level of provider education; activities which I believe result in large, though unquantifiable, savings to the trust funds.

AUDIT

The Medicare audit function represents the final and most all-inclusive opportunity for an intermediary to impact Medicare Program expenditures. The audit function occupies a "the buck stops here" position in the administration of the Medicare Part A Program. Audit activity directly addresses health care providers and their annual Medicare cost reports, the vehicle through which all providers make a final, all inclusive claim against the Federal Government for reimbursement for providing services to Medicare beneficiaries. Reduced to its essence, an institution's Medicare cost report is it's "final billing" to the Federal Government. This "final billing" is typically subjected to the scrutiny of a financial and compliance audit by the Medicare contractor. Such audit activity is the sole province of a Medicare audit organization within a contractor, due largely to the need for a highly educated and trained staff of professional accountants.

Medicare audit activity may be highly capsulized as the performance of the following duties:

- Ensuring required annual Medicare cost reports are filed by all health care institutions.

- Performing analytical reviews of the cost reports for the purpose of determining possible areas of excessive claims for reimbursement, violations of Program law or regulation, mathematical errors, and fraud or abuse of the Medicare program.
- Sending professional accountants to the provider site to perform a financial audit of the provider's books and records, if judged necessary and cost efficient.
- Producing a "final settlement" of the Medicare cost report. This final settlement determines the amount of total Program funds due to the provider for all services rendered to Program beneficiaries.

The Medicare audit role is analogous to that of the Internal Revenue Service. Both organizations perform the same generic tasks:

- Ensures the gathering of required financial filings to the Federal Government.
- Audits, selectively, the forms submitted to the government.
- Serves to create an all-important sentinel effect.
- Protects the Federal treasury from excessive expenditures and/or revenue short falls.

A contractor's audit effort is designed to protect the Medicare trust fund from unreasonable, unnecessary, or illegal expenditures. Contractors have been effective protectors of the Medicare trust fund through their audit activities. As an example, Blue Cross Blue Shield of South Carolina's Medicare audit activities in fiscal year 1988 were funded at a $1.7 million level. The clear result of this audit activity was a reduction in Program expenditures in the amount of $26 million, producing an audit return ratio of 15 to 1. Consistently presented with such results, it is difficult

to characterize Congress's investment in Medicare audit activity as anything but an extremely sound one.

Listed below are selected examples of audit findings produced through the Medicare audit efforts of one contractor, Blue Cross and Blue Shield of South Carolina. In all cases, the health care institution involved claimed reimbursement from the Medicare trust fund on its annual Medicare cost report.

- A hospital sought Program reimbursement for the costs (depreciation, interest, salary, maintenance) of operating a private health club on two floors of the hospital building. Such a claim for reimbursement, we believe, is contrary to Medicare law and regulation. Facts surrounding this issue were developed due solely to an on-site audit of the hospital and resulted in preventing, over a 3 year period, $370 thousand in unwarranted Program expenditures.
- A teaching hospital sought Program reimbursement for costs associated with its intern/resident teaching program. While such a claim is proper when correctly computed, our audit determined that the hospital had grossly erred in its computation. The contractor's corrected calculation resulted in one year Program savings of $600 thousand.
- We have detected instances of hospitals billing Medicare for services that were not rendered. A hospital sought Program reimbursement for the costs of servicing Medicare patients on days when the patients were not present at the hospital. The applicable facts were discovered only through an on-site audit of the hospital's books and records. Resultant savings to the Medicare trust fund were $37 thousand.

It is likely that the significant audit funding reductions proposed by the Administration will result in a classic false saving scenario. It is probable that the Administration's proposed 50% reduction in audit funding will in fact result in increased Medicare trust fund expenditures. Such a result is both shortsighted and supported by the irrefutable fact that audit funding has historically and consistently generated an enviable return on investment.

Significant audit funding reductions will surely diminish the "sentinel effect" of maintaining an effective audit presence. Such a loss is likely to further encourage increased Medicare trust fund expenditures, especially considering the proliferation in recent years of consultants and advisors descending upon health care institutions promising increased Medicare reimbursement in return for a contingency fee. As government and private payers have intensified their scrutiny of hospitals' billing and financial practices, many hospitals have turned to these "experts." Such a contingency fee contract recently encountered in South Carolina calls for payment by the health care institution to the consultant in the open-ended amount of 25% of all additional Medicare Program reimbursement obtained. Such approaches are increasingly attractive to providers and often are effective in increasing Program expenditures absent an effective counterpart -the Medicare audit function.

Although the crucial factor in this subcommittee's decisions governing Medicare audit funding is the effect on Medicare trust fund expenditures, such decisions will invariably impact the Program's contractors. A Medicare contractor faced with significant funding reductions will be forced to involuntarily terminate staff. At Blue Cross and Blue Shield of South Carolina, we anticipate that the Administration's proposed audit funding reductions will result in the termination of twenty experienced

auditors. The Congress has long recognized the value of maintaining a strong audit presence comprised of experienced accounting professionals, highly trained to protect the Medicare trust fund. Effective resources in the specialized field of Medicare audit activity are an asset to the Medicare Program. It is shortsighted to dismantle this asset due to insufficient funding. Such an occurrence would likely prove frustrating to the Congressional desire to control Medicare program expenditures and would surely be applauded by those seeking to enrich themselves at the expense of the Medicare trust fund.

MEDICARE SECONDARY PAYER

The Medicare Secondary Payer (MSP) operation ensures Medicare benefit payments are not made for services rendered to Medicare beneficiaries who have coverage from other payers primary to Medicare. The other payers whose coverage is primary to Medicare include employer group health plans covering the working aged and end stage renal disease, large group health plans covering disabled, workers' compensation, auto, liability, and no fault insurance. The MSP operation at Blue Cross and Blue Shield of South Carolina employs a total of 21 employees including two attorneys.

The primary functions of the MSP operation include the following:

- Reviewing submitted claims for indications of other coverage.
- Developing claims with indications of other coverage to determine if other coverage actually exists.
- Ensuring appropriate Medicare payment is made on claims for which Medicare is the secondary payer after primary payment is made.
- Tracking auto, liability, and workers' compensation cases to ensure Medicare benefit payments are either not made or are recovered from any settlement awards. This

activity could last two - three years for one individual case.

- Conducting outreach activities to provide information on MSP to beneficiaries, providers, attorneys, and insurers.

The Blue Cross and Blue Shield of South Carolina MSP operation has been successful and cost effective. Medicare benefit payment savings from MSP have grown each year from ~~$5~~ million in fiscal year 1985 to $39 million in fiscal year 1988. The fiscal year 1985 savings of $3 million was generated with funding of $280 thousand yielding an $11 return in benefit savings for each dollar of funding. The fiscal 1988 savings of $39 million were generated with funding of $672 thousand yielding a $57 return in benefit savings for each dollar of funding. These data indicate not only that each dollar of funding invested in payment safeguards is a good investment, but also that incremental funding of payment safeguards yields significant returns. This fact is demonstrated by the savings to funding ratios of $23:$1, $193:$1, and $94:$1 attributable to incremental funding each for fiscal year 1986, fiscal year 1987, and fiscal year 1988 respectively.

Medicare Secondary Payer savings are generated from a wide variety of sources and circumstances. A typical example in which MSP activity generated benefit savings is the case of a Medicare beneficiary who broke her hip in a fall in a retail store in September, 1985. A Medicare claim was submitted for hospital services related to the injury. Review of the claim by the MSP unit indicated the potential for other payer liability. The MSP unit contacted the beneficiary and learned that she was pursuing recovery against the retail store for damages. The beneficiary's treatment for injuries received stretched over a two year time period, during which Medicare payment was made on a conditional basis. The beneficiary received a settlement of $220 thousand in November 1987, at which time the MSP unit recovered $28 thousand of Medicare payments made over the two year period.

A second example of MSP recovery activity is the case of a Medicare beneficiary who was injured in an automobile accident in February, 1985. MSP unit review of the Medicare claim submitted for hospital services rendered as a result of the accident indicated the potential for coverage of the services by other payers. Initial MSP unit development of the claims with the beneficiary did not yield decisive evidence that another payer was liable. Through a subsequent inquiry from the beneficiary's attorney, brought about by previous MSP outreach activities, the MSP unit learned that the beneficiary was pursuing damages from the insurance company of the at-fault driver. Further information from the beneficiary's attorney, coupled with in-house research, indicated a total of $24 thousand dollars had been paid by Medicare for services related to the automobile accident. The entire $24 thousand in Medicare benefit payment made was recovered when the beneficiary received a $125 thousand settlement in April, 1988.

The Health Care Financing Administration in its fiscal year 1990 budget projects a reduction in MSP savings of $132.9 million if Medicare contractors' funding for this payment safeguard function is reduced by 30% as proposed by the Administration. I believe Blue Cross and Blue Shield of South Carolina's savings would be reduced by $25 - $35 for each $1 reduction in MSP funding. A 30% reduction would also severely limit our outreach activity. The reduced education of beneficiaries, providers, attorneys, and other insurers would further reduce growth of savings from the MSP program.

CLOSING

From 1980 to 1988, Medicare spending increased from 1% of the gross national product (GNP) to 1.6% and continues to increase at two to three times the general inflation rate. The complex forces at work that are driving up health care costs (inflation, technologies, demographics, defensive medicine) have a major fiscal impact on the

Medicare Program, the private sector, and the general public. For Medicare beneficiaries, higher costs mean higher premiums, deductibles and co-payments. We share your concern about the Medicare Program's growing impact on the federal budget. It is obvious that when Medicare expenditures rise disproportionately, other government priorities are difficult or impossible to meet. Unfortunately, there are no simple solutions. Reduced emphasis on Medicare contractor payment safeguard activities clearly is not a solution. Instead, such reductions would further increase the budget deficit as contractor oversight of trust fund payments declines.

The Medicare Program has become the most important "safety net" for protecting the health and financial well-being of the 34 million aged and disabled individuals in the United States. Maintaining the long term solvency of the Medicare trust funds has been and should be one of the foremost concerns of Congress as it looks to fiscal year 1990 and beyond. Adequate funding for Medicare contractor payment safeguard activities is a proven investment that will help protect the Medicare trust funds for the benefit of future generations of elderly Americans.

We would therefore urge you to maintain the sound investments you have made in the past in these vital areas and reject the shortsighted cuts proposed in the Administration's budget.

Blue Cross and Blue Shield of South Carolina and our national association stand ready to assist this subcommittee as it reviews Medicare contractor funding to ensure that the Trust Funds are adequately protected and that other services (claims payment, inquiries) are funded at a level sufficient to provide the best possible service to your constituents.

Thank you for giving me the opportunity to share my views on this vitally important issue.

STATEMENT OF ARTHUR LIFSON

Senator HARKIN. Thank you very much, Mr. Horton, for your testimony. Next I will go to Arthur Lifson.

Mr. LIFSON. Thank you, Mr. Chairman. I am Arthur Lifson of Equicor, Inc. I also am chairman of the Medicare Administration Committee of the Health Insurance Association of America. Equicor has contracts with the Department of Health and Human Services to pay Medicare part B claims for the States of Idaho, Wyoming, Tennessee, and North Carolina.

We will process more than 20 million medical claims during the fiscal year, the staff is 635 individuals in six locations. Equicor employees will approve for payment to doctors, nurses, and medical suppliers, more than $1 billion.

In the past few years, the administration and Congress have cooperated to secure sufficient funding to assure that Medicare claims are processed accurately and on a timely basis. It should be recognized that for fiscal year 1989 the contingency fund must be released to assure that that record is kept intact. Claims processing is Medicare contractors most critical task. Breakdowns in claims processing would put the entire program in peril. This committee has always been helpful in assuring that funds are available to avert that disaster.

The issue I wish to raise with you today is the relative value of Medicare contractors role in protecting the integrity of Medicare trust funds. The President's budget submission for fiscal year 1990 for Medicare administration contains $134 million less than contractors are currently spending on Medicare program safeguard activities, resulting in a reduction in savings from trust funds of some $1.13 billion.

In other words, the administration wishes to cut $134 million from the budget, even though by their own admission, it will increase spending by some $1.13 billion. If the old adage of penny wise and pound foolish has any basis in reality, these proposed cuts elevate it to a level of truth. Medicare contractors will lose some income and the services of some very experienced employees.

Those losses will pale in comparison to the absolute waste of hard earned taxpayer dollars at a time when every million counts, the waste of over $1 billion of trust fund moneys borders on the criminal. The Congress has always been concerned about waste, fraud, and abuse in the Medicare program and has held hearings on a regular interval since 1966.

While Congress can pass tougher laws, it cannot implement them. Even the best statute or regulations is worthless unless those with responsibility for protecting the program have means to do so. The President's budget is substantially deficient in providing those necessary resources for program safeguards.

While it is difficult to measure the fully determined value on dollars saved by program safeguards, I can assure you that the entire medical community is aware of our claims and utilization review work.

Equicor recently assumed claims processing responsibilities in the State of North Carolina. To our surprise we have experienced an unexpected surge in the number of requests for provider hear-

ings and appeals. The volume increase is due in no small part to the fact that as the new kid on the block, we are being tested. If we were to let up even a little, the word would get out quickly. The negative financial consequences are obvious. No one should be surprised that providers and provider organizations are aware of the pending cuts in program safeguards.

Mr. Chairman, you asked that we supply you with specific examples of fraud, waste, or mismanagement that Equicor program integrity staff have uncovered. I have included detailed descriptions of several such examples in the attachments accompanying the statement.

EXAMPLES OF FRAUD AND WASTE

I would like to summarize two examples quickly. A few years ago our medical review staff became aware that there were tremendous profits to be made in renting oxygen concentrators to Medicare beneficiaries and Medicare approved monthly rental rates. While I am certainly not adverse to profits, taking unfair advantage is inexcusable behavior.

Our staff was able to show that oxygen concentrators were available for lease from suppliers for as little as $28 per month. Rental agencies for durable medical equipment on the other hand could get as much as $291 from Medicare. The agency renting a concentrator could expect to make a profit of over 900 percent for taking no business risk. Effective March 15, 1989, the Health Care Finance Administration revised the payments safeguards for oxygen concentrators for all carriers nationwide, thereby extending to the Nation as a whole the savings first initiated in Tennessee.

It should be noted that Equicor's postpayment review staff will receive no credit for these savings since they do not represent dollars actually recouped, which has a negative impact on the carriers cost/benefit ratio.

The second example, the same medical review staff began a study of physician upcoding for overcharging for services provided beneficiaries during followup visits. It was noticed that an inordinate number of physicians were billing at the intermediate level rather than the limited level for routine followup office visits. The medical review staff scanned provider utilization summaries for physicians who billed at intermediate level and made educational contacts with those who regularly exceeded this type of billing, the norms for this type of billing.

The potential savings to Medicare from carrier initiated projects when implemented nationwide are staggering. A rough statement of the one-time program savings in just Tennessee for the diagnosis of upcoding of followup visits appeared common, approaches $1 million. Multiplied by the other States for the number of years the practice goes unchallenged, one can appreciate the enormity of the potential savings. Our attachment also contains a detailed description with regards to ambulatory care centers.

Mr. Chairman, if a contractor employs aggressive, highly skilled individuals to ferret out mistakes and abusive billing by providers and acts to nip it in the bud, there is presently no agreed upon way to document the ultimate savings to the program. HCFA's present

system for scoring medical savings only captures those dollars which derive from prepayment claims denials or reductions and those postpayment activities to recover inappropriate payments actually recoup the dollars.

On these activities Equicor regularly returns more than $9 on every $1 spent. Medicare's secondary payer will return $11 for every $1 spent. No question it is more difficult to document the savings that result from the dollars spent on educating providers. However, the simple effect of vigorous claims review is real.

I do not know how much more resources would have to be committed to these efforts before you get to the point of diminishing returns. In part, I surmise what is attempting to be showed by the chart. Clearly we are a long way from that point. In my judgment at least $200 million above the President's budget request is in order. The additional $200 million would assure the continued integrity of the trust funds. It will restore program safeguards to their 1989 level plus provide for inflation and claims growth. These funds will save at least $1.6 billion above the savings projected in the President's budget. Even at a reduced level of return, say 5 to 1, we would save an additional $1 billion.

Ed Dirksen, for whom this building is named, knew that that was real money when he constantly referred to $1 million here and $1 million there, I assume we were talking about real money. Today, we talk about billions.

To place the savings in prospective, the additional $200 million would produce savings that would pay for the President's request to expand Medicaid and restore the cuts proposed by President Reagan in that program, a start on the road to solving the uninsured problem.

PREPARED STATEMENT

Finally, Mr. Chairman, I would hope that the committee would find a way to segregate Medicare contractor payments funded from other budget items as our IRS agency. It makes little sense to sequester funds that will increase the deficit. Thank you.

[The statement follows:]

STATEMENT OF ARTHUR LIFSON

Mr. Chairman, members of the committee, I am Arthur Lifson, Vice President of the EQUICOR Inc, a joint venture of the Equitable Life Assurance Society of the United States and Hospital Corporation of America. We are in the managed employee benefits business and are the fifth largest group health insurance company in the United States.

My remarks today represent the perspective of a private insurance company which has served the Medicare program as a Part B carrier since its inception in 1966. I also serve as the current chairman of the Medicare Administration Committee of the Health Insurance Association of America, the principal trade association for the private health insurance industry. In all, there are eight commercial insurance companies who help administer the Medicare program[1].

EQUICOR has contracts with the Department of Health and Human Services to pay Medicare Part B claims for the states of Idaho, Wyoming, Tennessee and North Carolina. We will process more than 20 million medical claims during this fiscal year with a staff of 635 individuals in six locations. EQUICOR employees will approve for payments to doctors, nurses, and medical suppliers more than 1 billion in U.S. general revenues and monies from the Part B trust fund.

The administration of Medicare has long served as a model for a pragmatic approach to achieving an essential public policy objective through private means. The Medicare program has

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[1] The following HIAA member companies help administer Medicare as carriers and/or intermediaries: Aetna Life & Casualty, EQUICOR, General American Life Insurance Company, Mutual of Omaha Insurance Company, Nationwide Mutual Insurance Company, Transamerica Occidental Life Insurance Company, Cooperativa de Seguros de Vida de Puerto Rico, and The Travelers Insurance Company. Each contractor has served the Medicare program since its inception in 1966.

historically been administered on a contractual basis of no profit/no loss, an arrangement which has produced consistently diminishing administrative costs -- presently less than 1.5 percent of total Medicare outlays (see attachment 1).

In the past few years, the Administration and Congress have cooperated to secure sufficient funds to assure that Medicare claims are processed accurately and on a timely basis. After all, this is the Medicare contractors most critical task. Breakdowns in basic claims processing would put the entire program in peril. However, the issue we wish to raise with you today goes to a more controversial point--the relative value of the Medicare contractors' role in protecting the integrity of the Medicare trust funds.

The President's budget submission for FY 1990 for Medicare administration contains $134 million less than the contractors are currently spending on Medicare program safeguard activities. The following table describes the proposed FY 1990 budget and the anticipated savings resulting from contractor payment safeguard activities.

Administration's FY 1990 Budget for
Program Safeguard Costs and Projected Savings*
(in millions)

	FY 1989		FY 1990		
	Admin. Costs	Savings	Admin. Costs		Savings
Medical Review/ Utilization Review					
Part A	$ 62.9	$ 230.2	$ 36.8	(-26.1)	$ 134.7 (- 95.5)
Part B	99.1	693.7	77.8	(-21.3)	544.6 (-149.1)
Audit					
Part A	133.0	820.0	66.7	(-66.3)	59.4 (-760.6)

Administration's FY 1990 Budget for
Program Safeguard Costs and Projected Savings*
(in millions)

	FY 1989		FY 1990			
	Admin. Costs	Savings	Admin. Costs		Savings	
Medicare Secondary Payer						
Part A	32.6	1,016.9	35.7	(+3.1)	1,100.0	(+ 84.0)
Part B	35.5	291.0	12.3	(-23.2)	75.0	(-216.0)
Total	$363.1	$1,051.8	$229.3	(-133.8)	$1,913.7	(-1,138.1)

* From "Justifications of Appropriation Estimates for Committee on Appropriations, Fiscal Year 1990, US. Department of Health & Human Services, HCFA, Page 61.

To summarize this information, the Office of Management and Budget is in effect asking Congress to reduce payments to Medicare carriers and intermediaries for their payment safeguard activities in the following amounts:

Part A	Hospital Audits	-49.9%
Part A	Medical Review	-41%
Part B	Medical Review	-21.5%
Part A	Medicare Secondary Payor	+9.1%
Part B	Medicare Secondary	-65.4%

The fact that the Health Care Financing Administration is acknowledging an anticipated loss of $1.138 billion from the Medicare Trust Funds as a result of the $134 million cut in contractor payment safeguard funding is particularly astounding. If the old adage, "a penny wise and pound foolish" has any basis in reality, these proposed cuts elevate it to the level of a "truth". Medicare contractors will loose some income and the services of some very experienced employees. Those losses pale in comparison to the absolute waste of hard earned taxpayers' dollars. At a time when "every million" counts, the waste of over a billion of trust fund monies borders on the criminal.

The Congress has always been concerned about waste, fraud and abuse in the Medicare program and has held hearings at regular intervals since 1966. Back in 1977 special legislation

was passed to expand legal support for the FBI. Later the Congress created the Inspector General's Office within the Department of Health and Human Services to increase the government's ability to police Medicare and Medicaid fraud and abuse. On the whole, the Congress has done what it can legislatively to provide the statutory authority for the detection, investigation and prosecution of criminal fraud or abuse in these public programs.

While the Congress can pass tougher laws, it cannot implement them. Even the best statute or regulation is worthless unless those with responsibility for protecting the program have the means to do so. That responsibility starts with the Medicare claims processors. Unfortunately, our ability as Medicare contractors to patrol costly program misuse, waste and abuse, is a function of the resources made available to us.

As you can imagine, the overutilization of Medicare covered services is not easy to detect. We look for overbilling, billing for services that were not rendered, and other false representations on claims forms. We also have the difficult task of trying to determine when a medical service is reasonable and necessary and when reimbursement is sought for unnecessary or overutilized procedures.

The educational programs we run, the sophisticated monitoring activities we develop and the assistance we provide for the prosecution of fraud cases are all helping to control such activities. While its difficult to measure the full deterrent value on the dollars saved by these activities, I can assure you that the entire medical community is aware of our claims and utilization review work. In fact I have some fresh evidence of this.

EQUICOR recently assumed the claims processing responsibility in the state of North Carolina from the Prudential. When we projected our claims workload we assumed a stable beneficiary and provider population. To our surprise we are experiencing an unexpected surge in the number of requests for provider hearings and appeals from our payment decisions. It is my opinion that this huge volume increase is due in no small part to the fact that the new kid on the block is being tested. If we were to let up, even a little, the word would get out quickly. The negative financial consequences are obvious.

I wish to emphasize here that while criminal fraud and abuse is still a large problem in the $109 plus billion Medicare program, the larger problem, the one with the greatest fiscal impact on the trust funds and the citizen taxpayers is not outright criminal fraud, but misuse, mistakes, and petty abuse that when multiplied millions of times results in a huge drain to trust frauds.

As experienced managers of the day-to-day operations of Medicare contractors we see waste and abuse every day.

The following is a brief recitation of EQUICOR's program safeguard activities.

All Medicare carriers are responsible for making payments to beneficiaries as well as the physicians and suppliers who serve them. We receive and account for Medicare claims, determine the allowable charges for medically necessary procedures, make coverage decisions and determine primacy if there is the potential of other insurance. We are also responsible for computing and recovering overpayments and identifying irregular utilization patterns that deviate from accepted norms.

The program safeguard activities at EQUICOR's Medicare operations can be broken into two broad categories: prepayment screening of claims and postpayment reviews. What distinguishes the two is generally whether close scrutiny of individual claims occurs before or after the reimbursement check has been mailed out from our shop.

The predominant prepayment medical review activity performed by carriers is to program claims processing computers with predetermined automated screens that, with the help of skilled and experienced claims processors, will help identify claims for services which are not medically necessary or which should be paid by another primary payor. When the computer or clerk identifies a claim for medical services which does not meet Medicare's criteria, that claim will be isolated and evaluated by EQUICOR's staff of medical review specialists.

Post-payment medical review is a process by which the practice patterns of physicians and suppliers of medical equipment are compared to statistical norms for them and their peers in their specialty group. The purpose of this activity is to identify providers whose practice patterns depart from accepted norms and to correct overutilization of services by recovering overpayments, and educating providers on acceptable practice patterns. (For a list of areas where abuse has been detected nationwide, see attachment 1A.)

Claims examiners employed by EQUICOR utilize medical review guidelines that have been approved by our medical staff in making medical necessity decisions. We have a medical director on staff and physician consultants are also available to help with the more difficult reviews.

When these reviewers identify such cases, we work with the appropriate medical groups to correct the situation. We have generally found that nonconfrontational provider education can be very effective in changing undesirable billing or practice patterns and that the best way to get their cooperation is to present them with clearly defined guidelines that are based on sound data, are professionally prepared, and have the backing of their respected peers. In cases of extreme abuse and suspected fraud, we support the HHS Inspector General, the FBI and the U.S. Attorney General's Office in their prosecutorial roles.

Mr. Chairman, you asked that we supply you with specific examples of fraud, waste or mismanagement that EQUICOR program integrity staff has uncovered. I have included detailed descriptions of several such examples in the attachments accompanying this statement. I would like to now summarize three of them.

A few years ago, our medical review staff became aware that there were tremendous profits to be made in renting oxygen concentrators to Medicare beneficiaries at Medicare approved monthly rental rates (see attachment 2). By talking with oxygen suppliers, durable medical equipment renters, and equipment manufactures, my staff was able to show that oxygen concentrators were available for lease from suppliers for as little as $28 per month. Rental agencies for durable medical equipment, on the other hand, could get as much as $291 per month from Medicare based on the prevailing reimbursement rates at that time. With Medicaid, private insurance, or the beneficiary paying the Medicare copayment, the agency renting a concentrator could expect to make a profit of 939 percent. After developing the data to support our conclusion that Medicare's reimbursement rates were unreasonably high, we presented the case to HCFA and to the HHS Inspector General's Office.

Effective March 15, 1989, the Health Care Financing Administration revised the payment standards for oxygen concentrators for all carriers nationwide. Oxygen concentrators and all other respiratory equipment will be reimbursed on a fee schedule. These new payment standards will help to curtail abuse of oxygen concentrators and generate a savings to the program.

Special studies such as the one conducted by EQUICOR provide HCFA with areas of abuse that carriers feel have national significance. EQUICOR's postpayment review staff will receive no credit for these savings since they do not represent dollars actually recouped, which has a negative effect on the carrier cost benefit ratio.

In 1985, EQUICOR medical review staff began a study of physician upcoding or overcharging for services provided beneficiaries during "follow-up visits" (see attachment.) Our medical review staff had noticed an inordinate number of physician visits being billed at the "intermediate level" of care (HCPCS code 90060) rather than at the "limited level" of care (code 90050) which more accurately describes the care usually rendered during a routine follow-up office visit. We suspected that a growing number of physicians were using the intermediate level of care almost exclusively to describe their routine follow-up visits.

Medical review staff scanned the provider utilization summaries for physicians who billed an average of three or more follow-up visits per beneficiary at the intermediate level (code 90060) and made educational contacts with those who regularly exceeded norms for this type of billing. We generally found that as providers better understood Medicare descriptions of the levels of care, many agreed that the intermediate level should be reserved for those instances where follow-up visits required more

intensive care than normal. The Medicare program is, in our opinion, remarkably vulnerable to "up-coding" or coding to maximize reimbursement.

The potential savings to Medicare from carrier initiated projects when implemented nationwide are staggering. A rough estimate of the onetime program savings in Tennessee for the diagnoses where up-coding of follow-up visits appeared common approach $1 million (see attachment 3, page 3). Multiplied by the other states for the number of years the practice goes unchallenged one can appreciate the enormity of the potential savings. As in all cases of this type, our action plan calls for aggressive provider education. The Tennessee Society of Internal Medicine has discussed up-coding problems at its meeting and has offered its assistance in our efforts. The results of our study were also shared with the Inspector General's Office with our recommendation that a nationwide review of the problem be undertaken. (See copy of a recently released IG report on the upcoding problem, attachment 4.)

Our attachments also contain a detailed description of yet another EQUICOR medical review team study in 1988 -- this one on the billing practices of ambulatory surgical centers in Tennessee (see attachment 5). By carefully reviewing the billing practices of the 15 Tennessee ambulatory surgical centers, EQUICOR's postpayment medical review staff was able to identify major billing discrepancies in three of the 15. We were able to identify over $100,000 in overpayments in addition to preventing other future erroneous billings. With the number of surgical centers growing rapidly and the nationwide move toward increasing emphasis on out-patient surgery, our work in identifying over-payments to Tennessee ambulatory surgery centers has nationwide importance. We recommend aggressive reviews of ambulatory surgery centers until there is more widespread understanding of

Medicare coverage and payment policies. Naturally, this additional work will require new funding.

Overall, in 1988 EQUICOR's program integrity staff in Tennessee initiated 1165 program integrity reviews, which represents roughly 16 percent of all providers approved for participation in the Medicare Part B program in Tennessee. (Each of these reviews may involve the adjustment of hundreds of bills and effect as many beneficiaries.) Twelve of these cases (11 doctors and one ambulatory surgical center) were eventually referred to the regional Inspector General's Office for full scale fraud investigations. In the remaining cases, EQUICOR staff, consulting with the IG's office, contacted the providers involved and has been able to negotiate their continuing compliance with Medicare carrier manual guidelines. We are actively monitoring their practices.

Other carriers report similar projects under way or being developed by their medical review staff.

Mutual of Omaha is planing to expand its monitoring of extended stays in skilled nursing facilities. Medicare's new catastrophic insurance benefits provide full coverage for 142 days of skilled nursing facility care after the first eight days with coinsurance. Under these circumstances, the intermediary believes the program will be at greater risk of billings for noncovered care.

Transamerica Occidental's medical review staff recently noticed a rapid increase in the number of medical providers billing Medicare for noninvasive vascular studies. This procedure involves the use of an ultrasound device (or doppler) to perform an exterior scan of a patients veins to test for evidence of hardening or deposits. On investigation, it was

found that much of the surge in billings was due to testing at health fairs and at retirement centers without the knowledge or request of the Medicare beneficiaries attending physician and with no follow-up care provided. In 1983 Transamerica was billed $5,209,000 for doppler vein screening and approved $2,247,000 or 43 percent for payment. By 1986, Transamerica's monitoring and educational activities had produced a significant turn around. The number of doppler screeners billing Medicare was reduced from 185 to 88 and the carrier paid only 33 percent of the $10,272,000 billed. Transamerica believes its early monitoring and educational efforts have kept the spread of illegitimate providers from expanding into other states.

Transamerica's medical review staff also developed new guidelines for the reimbursement of transcutaneous electical nerve stimulator (TENS) units (describe). When the carrier noted huge increases in claims for TENS along with beneficiary complaints about the devices, the medical review staff uncovered a mass marketing assault in Los Angeles promoting the units. False medical necessity documentation was also being provided beneficiaries who were given units without medical need. Within four months after the new guidelines were implemented, Transamerica reported savings of over $600,000. The sentinel effect of close monitoring will continue to hold down abuse of this treatment for years to come.

Unfortunately, much of our story cannot be documented in dollars and cents. Hence, our problem with OMB, the Gramm-Rudman-Hollings Act and the Congressional Budget Committee scoring processes.

If a contractor employs aggressive, highly skilled individuals to ferret out mistakes and abusive billing by

providers, and acts to nip it in the bud, there is presently no agreed upon way to document the ultimate savings to the program.

HCFA's present system for scoring medical review savings only captures those dollars which derive from prepayment claims denials or reductions and those post payment activities that recover inappropriate payments. On these activities, EQUICOR regularly returns more than nine dollars for every dollar spent! For example, in 1988 EQUICOR charged Medicare $714,919 for the costs of prepayment medical review in Tennessee. This investment returned $7.1 million in real savings for a cost benefit ratio of 1/9.9. Our postpayment review activities cost Medicare $381,081 and produced $284,809 in recoveries to the program, so we reported 1/.75 ratio. However, the true value of postpayment review activities such as provider education on proper billing procedures and Medicare acceptable practice patterns probably prevented millions of dollars in bills we didn't see and millions of dollars in bills we didn't have to reduce or deny.

EQUICOR also received $929,100 in 1988 from HCFA to pursue bills to Medicare which should have been paid by other insurers. With this activity, we returned $11,180,368 for a 1/11 cost benefit ratio.

Furthermore, much of the annual savings in the Medicare program attributed to the detection of fraud and abuse by the Inspector General's Office were actually made possible by carrier and intermediary medical review and audit activities. If contractor funds for program safeguard activities are slashed, the Inspector General's Office will not get as many case referrals and will see fewer recommendations for special studies. There is no doubt in my mind that the IG's effectiveness will also be diminished.

No question it's more difficult to document the savings that result from the dollars spent on educating and monitoring providers, However, the sentinel effect which a vigorous claims review operation will produce is real!

I am concerned about the consequences this budget decision would have on our ability to continue to employ adequate numbers of qualified medical review and program integrity staff. While we would naturally strive to retain our best performing employees, we believe many of them would seek other employment. Our medical review staff are professionals with skills that are in high demand in the medical marketplace. They will most likely find employment with the hospitals, doctors and suppliers they have been monitoring. Should these talented individuals leave us, we will likely have to replace them with less experienced staff. As a consequence, we expect the quality of our work to also suffer.

Unfortunately, we will be forced to cut our payment safeguard staff by an even larger percentage than that called for in the proposed budget. This is due to the fact that we have a significant amount of fixed cost that is allocated in all Medicare budget lines, including payment safeguards. Costs such as rent, office equipment (rental, maintenance, depreciation), telephone systems, and nearly all of our EDP costs will either not decrease at all or will not decrease in the same proportion as the reduction in program safeguard funding.

We estimate we will have to eliminate 84 positions, nearly half of which are in our medical review area. This equates to the following staff reductions to meet FY 90's level of funding:

Part B Medical Review:	-25%
Part B MSP:	-60%

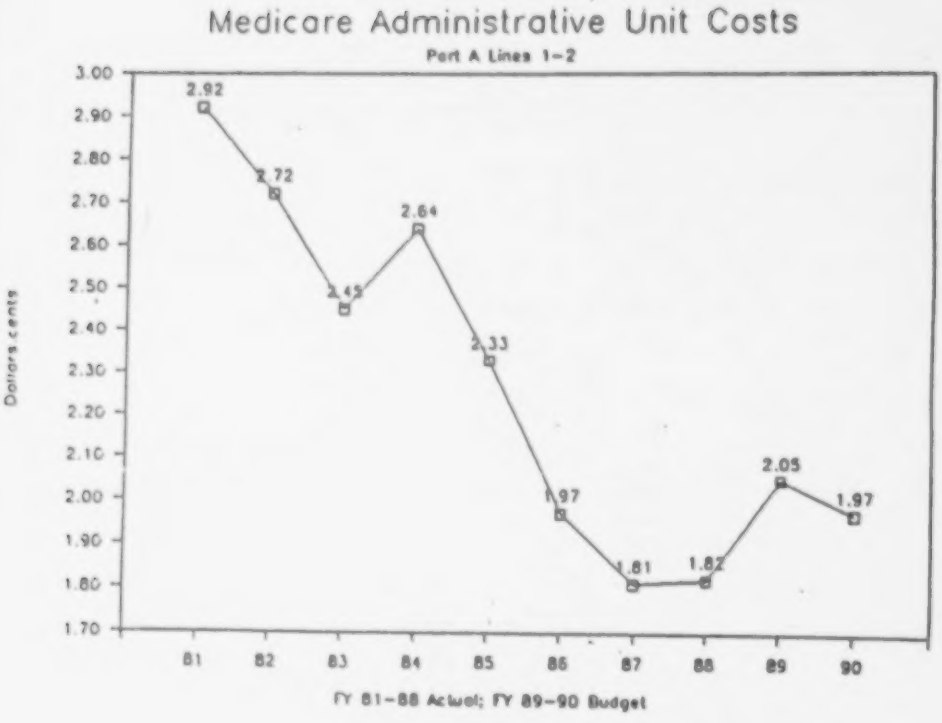
These reductions, in turn, will surely jeopardize our ability to detect, monitor, and recoup Medicare outlays.

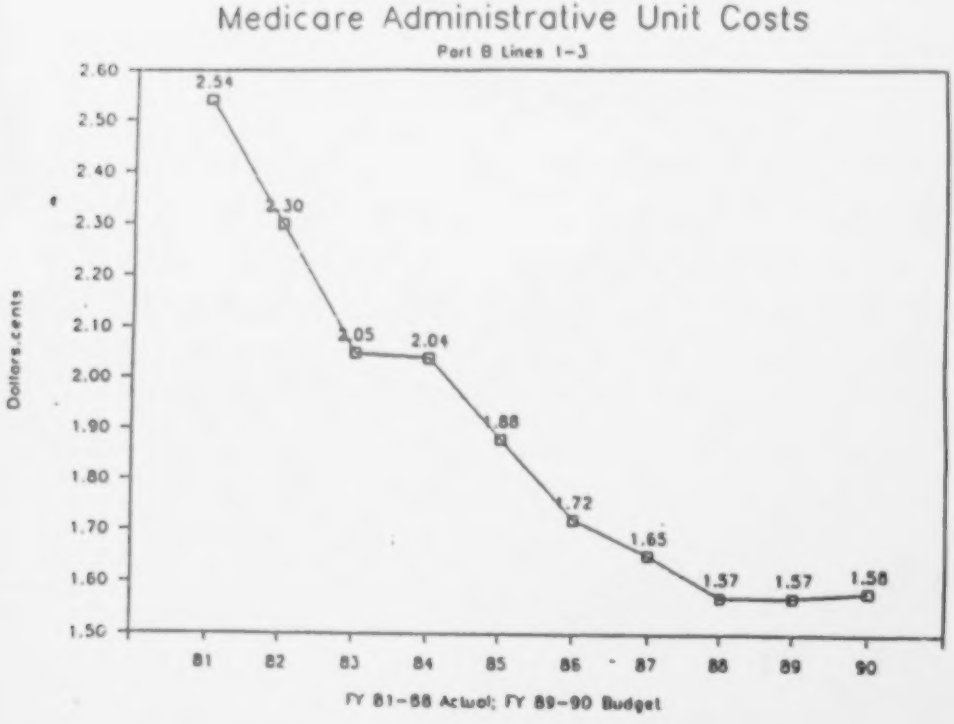
Lastly, we are mindful that in order to manage the FY 1990 budget, we would be forced to make staff reductions before October 1, 1989. This would also force us to account for the resulting severance payments as a FY 89 liability. This increases our FY 89 administrative budget dramatically -- money which has already been allocated. (If we waited until after October 1, severance would be a FY 90 expense and we would need to reduce even more staff to offset the severance cost.) Furthermore, due to the fact that EQUICOR gives its employees at least 90 days notice when jobs are eliminated, we believe many employees will leave for other jobs immediately which would adversely affect our ability to meet the workload and quality expectations for FY 1989.

Conclusion

I do not know how much more resources would have to be committed to these efforts before you get to the point of diminishing returns. Clearly, we are a long way from that point. It's my judgement that contractors need at least $200 million above the mark contained in the President's budget request in order to continue present activities and maintain the integrity of the Medicare Trust Fund. That $200 million would restore program safeguards to the FY 1989 level plus provide for inflation and claims growth. With these funds, contractors will save at least $1.8 billion more than the savings projected in the President's budget.

ATTACHMENT 1





ATTACHMENT 1A

medicare
Carriers Manual
Part 3 – Claims Process

Department of Health and Human Services
Health Care Financing Administration

Transmittal No 1276 Date NOVEMBER 1980

E. Postpayment Alert List.—The following areas of abuse have been repeatedly detected nationwide and should be considered when selecting cases for current year review (the list will be periodically updated):

- Absorptiometry – excessive services;
- Anesthesia – standby, especially with eye surgery;
- Ambulatory Surgical Centers – uncovered service is misrepresented as a covered service;
- Cataracts – excessive preoperative visual acuity testing;
- Colonoscopy – not indicated by diagnosis or medical documentation;
- Consistent use of a single code or level of care, e.g., all visits are comprehensive;
- Consultations – repetitive high level of visits/upcoding, visits to established patient, minor diagnoses that do not warrant a consultation, referrals within the same specialty, cross consultations from subspecialty to subspecialty that share the same parent specialty, e.g., internal medicine subspecialties;
- Cryosurgery – exclusively coded as 3 centimeters, which is the size of the freeze area rather than the actual lesion, when the actual lesion is much smaller;
- Culture and Sensitivity of Urine – repeat application of the test in a week or for several weeks after the organism is identified and sensitivity is established;
- Cystoscopy – billed separately from other endoscopic procedures;
- Dilatation and Curettage – unnecessary use of D and C and/or laparoscopy on the same date as a hysterectomy or certain other pelvic surgeries;
- Durable Medical Equipment – not covered if beneficiary is a resident of a facility that meets §1861(J)(1) of the Act;
- Echo M-Scans – routine screening not covered;
- EKG Interpretation – interpretation of EKG billed when physician utilized a computerized analysis of the EKG and did not do a manual review of the EKG readout;
- Endoscopy – Use of endoscopic procedures in lieu of less costly and medically adequate x-rays;
- Face Lifts – billed as removal of fatty tumors;
- Injections – may be medically necessary for the initiation of treatment, but not for the duration of all illness when oral medication would not be contraindicated;

o IPPU, Occasional - interval between treatments is inconsistent with the diagnosis, condition and or normal treatment frequencies, e.g., office patients who only receive one treatment a month;

o Keratosis - overutilization in removal of sebaceous keratosis;

o KUB - questionable medical necessity or split billing when billed separately on the same day as a GI and/or C-scan;

o Laboratory Test - frequent repeated testing when test results are within normal limits or not even used;

o Lesions - excision of physically impossible lesions; e.g., too large for face or extremity;

o Office Visits - upcoding and overutilization; e.g., frequent visits for chronic stable conditions which are not medically indicated.

o Patient Sharing - surgeons and medical physicians of like but different subspecialties sharing surgery patients; e.g., cardiovascular surgeon to cardiologist, neurosurgeon to neurologist;

o Place of Service - all services occur in the same type of facility; e.g., home, nursing home; circuit type of practice; same diagnosis for most patients;

o Portable X-rays - billing for two, rendering one;

o Pre- and Post-operative Care - not included in global fee, as applicable, regardless of the place of service.

o Pulmonary Therapy - multiple treatments per patient provided in a hospital setting that could have been provided on an outpatient basis, or excessive treatments per patient;

o Rehabilitation and Psychiatric Therapy - nonphysician services may only be reimbursed if the personnel are employed by and directly supervised by a physician and the services are provided incident to the physician's services;

o Renal Dialysis - standing orders used for laboratory tests that are of questionable, continuing necessity;

o Respiratory Therapy - too frequent, kickbacks, questionable necessity;

o Seat Lift Chairs - questionable repair bills, prescription authorized by physician with inadequate background knowledge of the patient to determine whether the patient would benefit from the equipment, all authorization forms prepared by the supplier and not the individual physicians, cost not reasonable;

o Standing Orders - periodic tests or treatments that may no longer be medically justified;

o Stress Testing - too frequent, no documentation of need;

o TURP - vasectomy billed as if a separate procedure on the same day or a different day (fragmentation, split billing);

o Vascular Testing, Noninvasive - questionable medical necessity, too frequent, poor documentation;

o X-rays - fragmentation; e.g., angiography with multiple vessel studies, brain scan and brain scan with flow study billed on the same day, repeated x-rays when previous results do not indicate abnormalities, routine use of chest x-rays;

MEDICARE BILLINGS SUBJECT TO ABUSE

1. Providers who bill a higher level of care than the service actually rendered.

2. Providers who fragment their charges in order to receive higher reimbursement.

3. Physicians who bill for post surgical care that should be included in the allowance for the surgical procedure.

4. Physicians who bill multiple surgical procedures.

5. Providers who resubmit claims with difference charges for the same service to try and receive multiple payments.

6. Providers who render medically unnecessary services; such as extended or concurrent hospital care.

7. Providers who bill for noncovered services, but word them so they will be paid.

8. False or altered certificates of medical necessity.

9. Providers who bill for services rendered after a beneficiary is deceased.

10. Podiatrists doing routine nail trimming, but billing so that services are allowed.

11. Duplicate billings to Veterans Administration and Medicare.

12. Chest Xrays.

13. Fragmentation of lab tests.

14. Excessive supplies in rental of infusion pumps.

15. Billings to Part B for DME when Part A benefits are exhausted.

16. Three wheel scooters for wheel chairs.

17. Home Xray services.

18. Prosthetics and DME suppliers forging physicians' names.

19. Billing of equipment prior to delivery to get a predetermination of benefits.

20. Doppler studies done when patient has not seen the ordering physician in an extended period of time.

21. Anesthesia time units overstated.

22. Acupuncture.

23. Surgery billings held up for several months while post operative billings are filed and paid.

ATTACHMENT 2

RECOMMENDATION FOR HCFA STUDY

"OXYGEN CONCENTRATORS"

We are providing information we have gathered regarding the possible abuse of oxygen concentrators. We feel our concerns may have national significance.

We have been advised that one concentrator manufacturer has been contacting suppliers offering to lease oxygen concentrators for as little as $28 each per month. We assume for suppliers to receive this rate, concentrators are rented in bulk. This manufacturer is reported to be the John Bunn Manufacturing Company of Tonawanda, New York. Another manufacturer, Oxygen Enrichment of Albany, New York, has advised they lease concentrators for $38 each per month for three years, and to receive this rate they do not have to be ordered in bulk. At the end of three years, the leasee may buy the concentrator for 10% of the original cost, or return it and lease a new one. Ten percent of original cost can range from $100 to $140 depending on the number leased. We have also been informed that leasing companies in Nashville, Tennessee offer concentrators for anywhere from $65 to $80 per month. The leases are usually for four years and require the first and last month's payment up front; interest is also charged. Flexlease agreements are also available where the supplier does not have to pay anything the first three months, presumably to give them time to place the machine and start their cash flow on it. Reportedly, one leasing company, Skyland Hospital Supply of Bluefield, West Virgina, leases machines at $50 per month. One of their customers is National Health Corporation which owns approximately thirty nursing homes in Tennessee.

Currently, Tennessee approves up to $291 per month for the rental of an oxygen concentrator. Prior to Regional Office reorganization, regional comparability was taken into consideration in applying inherent reasonableness for the majority of reasonable charges on DME. Beginning in 1982, reasonable charge for rentals was based on the preceeding year's prevailing charge for Tennessee and increased by the economic index. This had to be done this way, or otherwise, Medifac, who is our largest volume supplier would set the reasonable charge for Tennessee on most durable medical equipment. The majority of reasonable charges for purchase equipment are taken from catalogue prices in the absence of valid profile data. We have been told that when purchased in bulk, concentrators can be bought for as little as $1000 apiece. Bought directly, one at a time they range from $1250 to $1400 apiece. We currently can allow $2,665 on the purchase of a new concentrator.

Our concern is over the inordinate amount of profit conceivably being made on these concentrators. For instance, on an assigned claim, a supplier leasing a concentrator for $28 a month and renting it for say $300 per month can currently expect to receive up to $291 per month in compensation from Medicare and either Medicaid, private insurance, or beneficiary payment of the co-insurance amounts. This amounts to a 939% profit.

The following figures illustrate the potential amounts of profit to be made on oxygen concentrators over a five year period, based on the various information we have received.

10 CONCENTRATORS

(Leased at $28.00 per month for 5 years)

Suppliers Cost	Approved Amount	Profit
$16,800.00	$174,600.00	$157,800.00

(Leased at $38.00 per month for 3 years then purchased at 10% of original cost)

Suppliers Cost	Approved Amount	Profit
$15,080.00	$174,600.00	$159,520.00

(Purchased new at $1,400.00 apiece)

Suppliers Cost	Approved Amount	Profit
$14,000.00	$174,600.00	$160,600.00

100 CONCENTRATORS

(Leased at $28.00 per month for 5 years)

Suppliers Cost	Approved Amount	Profit
$ 168,000.00	$1,746,000.00	$1,578,000.00

(Leased at $38.00 per month for 3 years then purchased at 10% of original cost)

Suppliers Cost	Approved Amount	Profit
$146,800.00	$1,746,000.00	$1,600,000.00

(Purchased new at $1,000.00 apiece)

Suppliers Cost	Approved Amount	Profit
$100,000.00	$1,746,000.00	$1,646,000.00

Even allowing for the expenses of maintenance and repairs, which according to our sources are minimal and keep the concentrators going almost indefinitely, you can see the potential for large profits in the concentrator business if reimbursements are allowed to remain at such unrealistic levels. One manufacturer told us the usual practice is for suppliers to keep concentrators six or seven years with no repairs and then having gotten their money out of them ten times over, just discard them and rent or purchase new ones.

There are no national mandates requiring that contractors establish customary charges for DME through either regional comparability or economic index. Even if we reverted back to establishing reasonable charge based on regional comparability, there is nothing to hold down increases, therefore, we suspect the allowed amounts would continue at an alarmingly high rate. As a guide for establishing reasonable charge on oxygen concentrators, we recommend obtaining lease/purchase agreements and allowing a 40% mark-up. This can only be done when Medicare Carriers are privileged to the lease or purchase agreements between manufacturers and suppliers. Currently, there is no provision in the Medicare Law that gives the Carrier the authority to require access to these agreements.

We believe this potential for large profit from a small cash outlay and minimal maintenance is what has caused the boom in DME suppliers dealing in the concentrator business. Durable medical equipment suppliers across the state who were providing oxygen to low-volume users (i.e., those using less than 240 cubic feet per month) and not billing Medicare (since regulations do not allow for coverage of oxygen prescribed to patients PRN), have complained to us that other suppliers have come in and replaced their tank equipment with oxygen concentrators. When the medical necessities are pulled and reviewed, the needs for the oxygen concentrators are supported by the amounts of daily use prescribed and by the PCO_2 and PO_2 levels given by the doctors on the forms. Yet many beneficiaries, when contacted, advise us they are using the machines less than the minimum number of hours a day required to demonstrate medical necessity. This minimum number of hours is 10, some beneficiaries indicate they use their concentrators only 1 or 2 hours per day, or even less, "as needed". Even though a certain PO_2 level is also required in order to establish the medical necessity for an oxygen concentrator, we have been

advised by a respiratory therapist that you can obtain any level you desire simply by the amount of activity you subject a patient to before performing the test. Several DME suppliers employ hospital based respiratory therapists who may be the ones supervising the performing of these tests since many of the physicians do not do these tests themselves but send the patients to the hospital for them.

It is often difficult to obtain information substantiating a beneficiary's need since doctors do not always keep records of what durable medical equipment they have prescribed for a patient nor do they keep the completed medical necessity forms in their files to which to compare the forms we send them for verification. We feel this is because physicians often sign blank medical necessity forms and let the suppliers act in a secretarial capacity for them by completing the form. Thus, it is conceivable that the physician does not have a copy and quite often the information we receive is either incomplete or incorrect. Even though we have the authority to demand that a specific supplier with a problem no longer act in a secretarial capacity, we have found that many doctors still resist completing forms themselves and have the suppliers complete the forms before they sign them, quite frankly, apparently without a glance at the information on the form. Finally, some doctors take the path of least resistance and prescribe what the patient wants rather than what would be most appropriate (and least expensive) for the patient's condition.

It is our opinion that since the qualification for Medicare coverage on oxygen concentrators (as well as other durable medical equipment) rests on the information contained on the medical necessity forms received with the claims, the physicians should be required to be more conscientious in their provision of medical necessity information. If they are required to share the responsibility and are held accountable in some manner (such as the possiblity of facing exclusion from the Program) for contributing to the making of erroneous payments because of false or incorrect information on the medical necessity forms signed by them, they may become more cautious and responsible in these cases.

In light of all of the foregoing information, we feel the door is wide open for abuse in the field of oxygen concentrator suppliers, and heartily agree with Inspector General Richard Kusserow that the Medicare Program could save a great deal of money in its handling of reimbursement in this field. We see the need for stiffer Medicare regulations regarding oxygen concentrator reimbursements and the addition of sanctions to be applied against physicians who repeatedly provide or endorse erroneous medical necessity information.

ATTACHMENT 3

The EQUITABLE Life Assurance Society of the United States

Judy Webb, Supervisor
Program Evaluation

DATED AT Nashville, Tennessee
October 21, 1985

Upcoding - 1985 Special Study Topic

REPLYING TO YOURS OF

Each year we receive an individual provider utilization summary for each physician who submits claims for Medicare reimbursement in Tennessee. This summary provides a break-out of the different categories of the physician's practice as specified in MCM, Section 7512 B.

Our study objective for 1985 was based on the category for medical visits; specifically, the HCPCS codes used to describe these visits. We have become increasingly aware of a trend toward billing follow-up office visits at the intermediate level of care (code 90060) rather than at the limited level of care (code 90050).

The CPT Manual, which contains the level I codes of HCPCS, lists a description of the levels of care outlined in the manual. The description for limited level of care adequately describes the care usually rendered during a follow-up office visit. Many physicians, however, use the intermediate level of care almost exclusively to describe their usual follow-up visits. This results in excessive program reimbursement for usual follow-up visits. Therefore, we decided the theme for our special study for this year would be, Upcoding.

We began by scanning each of the provider utilization summaries for those physicians who frequently use code 90060 to describe their usual follow-up visits. We found that some of the providers use levels of care higher than intermediate (extended level of care code 90070 and comprehensive level of care code 90080) to describe their services. Providers who use any of the higher level codes to describe their follow-up office services and exceeded certain parameters for this type billing were scheduled for contact during the project.

At the beginning of the project our criteria for contact included any provider who billed the majority of his follow-up visits using a description higher than limited level of care. We then decided it would be more beneficial to only contact the ones who billed an average of three or more of their follow-up visits per patient at the intermediate or higher level.

A letter was drafted, a copy of which is attached, (see Exhibit I) which pointed out the actual statistics from the individual's utilization summary for one year's claim activity. An explanation of the appropriate level of care code to be used for follow-up visits was given in the letter. The providers were asked to improve their billing practices and were notified that failure to do so could be considered abuse of the Medicare program. A total of 438 letters were mailed between the period January 25, 1985 and September 10, 1985. We wanted physicians of the same specialty to receive the letter at about the same time so we divided our mailings by the their specialty. This method was helpful when the inquiries began coming in.

We received numerous responses to the letter. The majority of the providers telephoned. There were several who wrote letters and a few corresponded through their Congressmen. Many of the physicians who called appeared not to have thoroughly read the letter before placing their call. After a complete verbal explanation the majority advised they had merely assigned a code to their service without giving due consideration to the description of the code. Several of the physicians were complimentary of our attempt to advise them of the proper codes to use for their office visits. Copies of some of these letters are attached. (see Exhibit II)

The main concern was centered on the allowable fee for the limited level of care. We have explained that the erroneous coding, in many instances, has set a fee for the intermediate level of care that was actually expected for the limited level.

As the providers better understood the descriptions of the levels of care the majority agreed that the intermediate level of care should be reserved for those instances when care over their usual level is rendered. We explained that the only way the allowable fees for these services can be corrected is for the physicians to adjust their coding.

The May 1985 report from the President's Council on Integrity and Efficiency titled "Using The Computer Against Fraud And Abuse In Medicare And Medicaid", lists upgrading (upcoding) of program services as the number two major program vulnerability. We feel a project such as the one we have done would be of national significance in program savings. Copies of pertinent portions of the report are enclosed. (see Exhibit III)

The program savings to be derived from this project are almost incalculable but the following is, we feel, a conservative estimate of the yearly savings.

Specialty	*Estimated Number of Visits Upcoded	Estimated Overpayment
General Practice	46,714	$231,701.44
General Surgery	15,125	76,835.00
Allergy	254	1,290.32
Otology, Laryngology, Rhinology	3,256	16,540.48
Cardiovascular Disease	2,902	14,742.16
Dermatology	4,147	21,066.76
Family Practice	33,749	171,444.92
Internal Medicine	57,875	294,005.00
Osteopath	2,279	11,303.84
Pulmonary Diseases	986	5,008.88
Thoracic Surgery	121	614.68
Urology	1,757	8,925.86
Mixed Specialties	16,603	84,343.24
	Grand Total	$937,822.28

*Sixty percent of total visits billed at higher levels.

We considered that at least sixty percent of the upcoded visits should have been billed at the limited level of care. The difference in allowance for general practitioners and osteopaths is $6.20 per visit. The difference in allowance for all other specialties is $6.35 per visit.

The far-reaching effects of this endeavor cannot be estimated as many of the providers who called advised they had surveyed the other providers in their area and they all coded alike. By means of these conversations providers who were not scheduled to receive the letter learned of its purpose.

We received a call from the chairman of one of the large professional practice programs at one of the teaching facilities, who had heard about the upcoding letter and wanted to discuss it further. The chairman, who is also a practicing M.D., felt the letter was needed and planned to discuss the importance of proper coding at their next meeting. This project was also discussed with the Tennessee Society of Internal Medicine. Therefore, we have received assistance from the medical community in handling the problem.

The providers were notified in the letter that their claims would be reviewed again in approximately one year to determine if there had been an appreciable change in their billing habits. Due to this re-evaluation our project will continue through 1986 and 1987.

Carolyn Allen, Representative
Program Evaluation
The Equitable
Telephone (615) 244-5600

Exhibit I

THE EQUITABLE
MEDICARE ADMINISTRATION
P.O. Box 1485
Nashville, Tennessee 37202

Dear Dr. _____:

RE: Upcoding

As the Medicare Part B carrier for the state of Tennessee, we are charged with the responsibility for not only determining the allowable charges for services rendered but also the medical indications for either the frequency or the level of those services. Accordingly, reviews are conducted periodically to determine those cases which may represent a potential problem.

In checking our records, we found what appears to be a problem on your part with upcoding. The following chart shows the frequency of certain levels of care billed to Medicare on claims for services processed in _____. As you can readily see, intermediate or higher levels of care are billed far more often than brief or limited levels of care.

Please note the purpose of this letter is not to address your fee for service but the codes you assign to those services. Also, please keep in mind that we only have access to statistics derived from your Medicare practice, not your practice as a whole.

NEW HCPCS CODE	DESCRIPTION	FREQUENCY BILLED
90040	Follow-up OV, Brief Service	
90050	Limited Service	
90060	Follow-up OV, Intermediate Service	

It is expected that the majority of a physician's follow-up visits would be at the limited level of care, a smaller number at the intermediate level, and an extreme minority at the extended or comprehensive level. When a physician renders services beyond his usual level of care, we would expect it to be billed at a higher level. However, if a review of a physician's practice indicates that a higher level of care is billed in excess of the norm, we have no alternative but to consider that as his usual service and base our coverage accordingly.

Regarding brief or limited visits versus intermediate visits, Medicare considers each physician's usual service as his typical service despite the time spent or charge made. If a physician generally spends more time with his patients than other physicians do, that is his usual service regardless of what constitutes the usual or intermediate services of other physicians. A physician, of course, establishes his own charges for his services, and if he feels he generally spends more time with his patients than other physicians usually spend with theirs, he may find it necessary to have a higher charge for his usual service than other physicians. Nevertheless, it is still considered to be his usual service and should be coded or identified as such. Descriptions of levels of care begin on page XIV of the current CPT-4 manual and the description for limited level of care (code 90050) adequately describes the usual follow-up visit.

As upcoding has become a prevalent problem on claims received from physicians of all specialties, we are addressing it at this time in an educational manner. However, we are obligated to advise you that continuation of the practice,

after this notification, could be considered as an attempt to abuse the Medicare program which could result in corrective action. Your claims billed during 1986 will be reviewed to see if there has been an appreciable change in your pattern of billing. If a problem should continue to exist, we will review a random sample of your claims to determine if medical indications support the higher level(s) of care consistently billed. If justification cannot be found, it may be necessary to assess overpayments and/or enter prepayment screens against your claims.

We trust this letter has brought the coding problems to your attention and that you will review the claim coding procedures in your office and make any necessary changes. If you have any questions regarding this matter, please contact our office.

Sincerely,

Program Evaluation

ATTACHMENT 4

PROBLEMS WITH CODING OF PHYSICIANS SERVICES: MEDICARE PART B

OFFICE OF INSPECTOR GENERAL

The mission of the Office of Inspector General (OIG) is to promote the efficiency, effectiveness, and integrity of programs in the United States Department of Health and Human Services (HHS). It does this by developing methods to detect and prevent fraud, waste and abuse. Created by statute in 1976, the Inspector General keeps both the Secretary and Congress fully and currently informed about programs or management problems and recommends corrective action. The OIG performs its mission by conducting audits, investigations and inspections with approximately 1,200 staff strategically located around the country.

OFFICE OF ANALYSIS AND INSPECTIONS

This report is produced by the Office of Analysis and Inspections (OAI), one of three major offices within the OIG. The other two are the Office of Audit and the Office of Investigations. The OAI conducts inspections which are typically short-term studies designed to determine program effectiveness, efficiency, and vulnerabilities to fraud or abuse.

THIS REPORT

This report is entitled "Problems With Coding Of Physician Services: Medicare Part B." The purpose of the inspection resulting in this report was to: determine whether there are significant problems regarding coding of office and hospital visits; identify the reasons for

coding problems; and recommend changes in policies or procedures governing coding matters, as appropriate.

This inspection was performed by the following persons:

Atlanta
Doug Marshall *(Project Leader)*
Joe Townsel
Paulette Roberts

Headquarters
Penny Thompson
Mary Hogan

EXECUTIVE SUMMARY

PURPOSE

Health services and supplies are reported and billed to Medicare by way of a numeric coding system. This inspection was conducted to:

(1) determine whether there are significant problems regarding coding of physician office and hospital visits;
(2) identify and examine reasons for coding problems; and
(3) recommend corrective measures, as appropriate.

BACKGROUND

Medicare is a federally funded program providing health care to the aged and disabled. The program is administered by the Department of Health and Human Services, Health Care Financing Administration (HCFA).

Medicare is divided into two parts. Part A includes hospital services and supplies. Part B includes physicians' services and "durable medical equipment" such as wheelchairs. This inspection deals with Part B. Payments for Part B Services and supplies are made through private insurance companies, known as "carriers," working under contract with HCFA.

In 1983, HCFA required all carriers to institute the HCFA Common Procedures Coding System (HCPCS). The use of HCPCS was intended to bring about uniformity in interpretation and reporting of medical services and supplies provided to Medicare beneficiaries. Under HCPCS, physician services are reported as five-digit codes defined in the American Medical Association's *Current Procedural Terminology* (CPT). Some services, such as physician office or hospital visits, are also designated by a procedure "level" which takes into consideration the wide variations in skill, effort, time, responsibility and medical knowledge required under different circumstances.

This inspection examines the issue of uniform coding and factors which influence coding choices. It analyzes statistics on the frequency of specific procedure codes billed to Medicare carriers. As a means to verify and interpret the statistical findings, interviews were held with 142 persons knowledgeable of physician billing habits, predominantly at the HCFA regional offices and Medicare carriers.

FINDINGS

There are wide variations in coding of office and hospital visits under what is intended to be a uniform coding system. Problems described here relate to coding of "established

patient office visits" and "subsequent hospital care" (daily visits to hospitalized patients).

- The principal reason is differences in interpretation of the services each code represents. Differences in interpretation may be attributable to the large number of office and hospital visit codes available under CPT and a lack of clear distinction among code level descriptions.

- Reimbursement is also a factor, although code selection is intended to be based solely on the services rendered.

RECOMMENDATIONS

The HCFA should:

- Consult with the American Medical Association (AMA) to reduce the number of codes.

- Consolidate codes for payment purposes.

- Designate codes for "routine" office and hospital visits.

- Consult with the AMA on terminology changes and modification of the CPT manual.

- Educate providers on proper coding.

HCFA COMMENTS

The HCFA recognizes the problems which exist with coding of physician services and agrees with all of the OIG's recommendations for correcting them. A HCFA representative recently presented the OIG's findings and recommendations to the AMA's CPT-4 Editorial Panel at a meeting in Washington, D.C. Other discussions between HCFA and the AMA regarding coding problems have also taken place over the past several months. The HCFA believes these actions "... *will have a positive effect on resolving the concerns and issues raised in this audit.*"

INTRODUCTION

BACKGROUND

Medicare is a federally funded program which provides health care to the elderly and disabled. It is administered by the Department of Health and Human Services, Health Care Financing Administration (HCFA). Services covered under Medicare are divided into two general areas. The first, known as "Part A," includes hospital services and supplies. The second, "Part B," includes physicians' services and "durable medical equipment" such as wheelchairs. This inspection deals with Part B.

Reimbursement through Private Carriers

Payments for services or supplies covered under Part B are made through private insurance companies ("carriers") under contract with HCFA. Each carrier has responsibility for processing claims in a designated geographic area. The HCFA provides direction to the carriers on all payment matters. It is also responsible for assuring that carriers are adhering to program policies and procedures governing payment.

Procedure Codes for Billing

In the past, physicians and suppliers submitted bills to carriers using narrative descriptions or numeric codes to identify the services they had rendered. Many different coding systems were used. Little similarity existed among the many methods used to bill Medicare.

In 1983 HCFA required all carriers to adopt the HCFA Common Procedures Coding System (HCPCS). The use of HCPCS was intended to bring about uniformity in defining and reporting medical services. This uniformity would enable HCFA to analyze Medicare services nationwide and would provide reliable information for Medicare policy making. Such analyses were not possible under the former hodgepodge of billing methods.

Present Coding System

Under HCPCS, physician services are described through use of the American Medical Association's *Current Procedural Terminology* (CPT). The CPT consists of a series of five-digit codes each representing a particular service (procedure). When the procedure is a physician visit, the extent of the service rendered is also designated by a procedure "level." These levels take into consideration the wide variations in skill, effort, time, responsibility and medical knowledge required under different circumstances.

The following table shows the code and corresponding level designations for "established patient office visits" (any visit after the first) and "subsequent hospital care" (daily visits in a hospital after the day of admission). Recent data obtained from HCFA indicates that these two services together account for nearly 25 percent of the total number of services billed, and 16 percent of the total payments made under Part B.

CPT CODE AND CORRESPONDING LEVEL

OFFICE	LEVEL	HOSPITAL
90030	Minimal	N/A
90040	Brief	90240
90050	Limited	90250
90060	Intermediate	90260
90070	Extended	90270
90080	Comprehensive	90280

Reimbursement Amounts

Reimbursement rates for the various code levels are set by each carrier for its own area. Carriers establish their rates based on "prevailing charge localities," specific geographic areas

where physicians' charges for services are very similar. In most instances, the higher the level of service billed the higher the reimbursement.

Uniformity Lacking

The HCFA Part B Medicare Annual Data System (BMAD) provides calendar-year data by procedure code for *every* procedure processed by each carrier for the year. Under a uniform coding system, one would expect to find similar billing patterns from carrier to carrier. Analysis of the 1984 BMAD, however, reveals that patterns of billings for "established patient office visits" and "subsequent hospital care" vary greatly. Not even a semblance of the uniformity sought under HCPCS is evident in the BMAD statistics.

PURPOSE

This inspection examines in detail the lack of uniformity in coding of claims in these two high volume areas: physician office visits by established patients, and physician visits to hospitalized patients.

The inspection has three main objectives:

(1) to determine whether there are significant problems regarding coding of office and hospital visits;

(2) to identify and examine reasons for coding problems; and

(3) to recommend corrective measures, as appropriate.

METHODOLOGY

Findings reported here are based on analysis of data contained in the Part B Medicare Annual Data (BMAD) Procedures File for 1984-1986. Other documents and statistics related to physicians' coding of medical services, listed in appendix A, provided documentation of the coding process and the conclusions of prior studies.

To help interpret the statistical findings, 142 persons knowledgeable of physician billing habits were interviewed. These individuals were: 99 persons (including 9 physicians) from all 47 Medicare carriers; 15 from HCFA's central office and 24 from HCFA's 10 regional offices; 3 from other government offices; and 1 from the American Medical Association.

FINDINGS

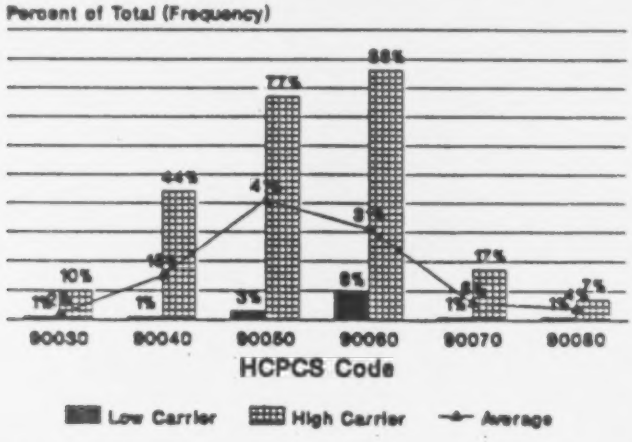
THERE ARE WIDE VARIATIONS IN CODE USAGE

An analysis of the 1985 and 1986 (latest available) BMAD statistics reveals that 1984 variations in billing patterns among carriers continue. The following charts illustrate some of these variations.

Figure A shows, for example, that for code 90060 one carrier had 86 percent of its total billings for "established patient office visits" at this level. Another had just 9 percent. The average percentage of this code reported by all carriers was approximately 31 percent.

Information on patterns of billings at all carriers is contained in appendix B of this report.

Figure A Bills to Carriers for Established Patient Office Visits (1986)

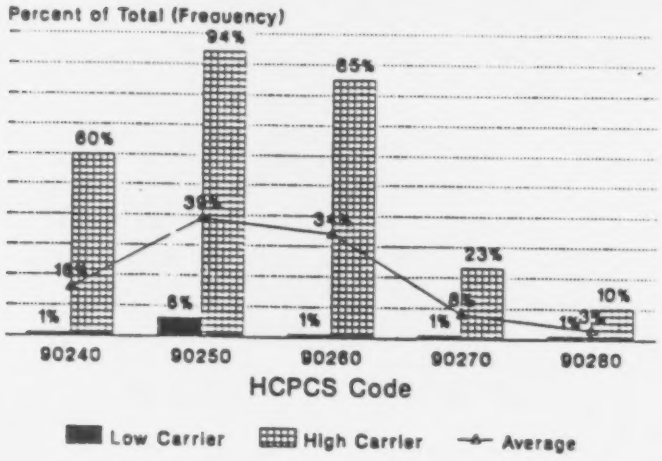


PRINCIPAL REASON IS DIFFERENCES IN INTERPRETATION

Both Group Health Insurance (GHI) and Empire Blue Shield pay claims for portions of New York City. The city is considered one prevailing charge locality for purposes of setting reimbursement rates. However, while GHI has 85 percent of its billings for subsequent hospital care at the intermediate level (90260), billings at Empire are more evenly distributed, with only 34 percent at the intermediate level. Similarly, Blue Shield of Montana and Equicore of Wyoming both serve predominantly rural populations. Blue Shield, however, has 53 percent of its hospital visits billed at the "brief" level (90240), while Equicore has only 10 percent at this level. These and similar comparisons show that differences in billing patterns cannot be attributed to differences in the geographic location of Medicare patients.

The nature of the coding problem was examined in interviews with HCFA and carrier staff. These interviews revealed that the principal reason for variations in billing patterns among carriers is the differences in interpretation of codes by both carriers and providers. (Providers of Medicare Part B services are physicians and suppliers of medical services.) When carriers first converted to HCPCS, HCFA permitted them considerable flexibility in translating the codes under their old systems into the new CPT codes. This flexibility led, for example, to some carriers converting an old 9004 ("routine follow-up office visit") to the CPT code 90040 while others converted this code to CPT code 90050.

Figure B Bills to Carriers for Subsequent Hospital Care (1986)



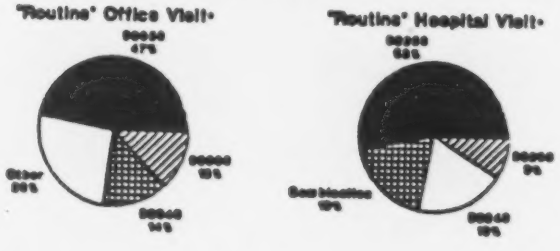
No National Policy on Coding "Routine" Visits

Variations in how carriers converted their old coding systems into the new are most evident in the differences in what CPT codes they chose to designate the "routine" level for office and hospital visits. "Routine" is defined as the service a physician would normally be expected to render most often.

These differences for routine visits were noted several years ago by HCFA's Region VI office in Dallas. Regional staff requested clarification from the HCFA central office (appendix C). The HCFA's response (appendix D) states that the 90050 and 90250 (limited) levels of office and hospital visits are the "most correct" codes to designate routine services. The response further states that it is possible that some carriers, based on reimbursement considerations, may have designated both the "brief" and "limited" levels as routine. While this is not the preferred method, HCFA apparently considers it acceptable. According to HCFA staff, levels *higher* than the limited level would not be correct. With the exception of Dallas, HCFA has not communicated this position to any of its other nine regional offices.

As illustrated by the following charts, carriers continue to consider a number of different codes, or combinations of codes, as routine. Only about half of the carriers indicated they would use the 90050 or 90250 code which HCFA considers to be "most correct":

Carrier Respondent Opinions Figure C



Lack of uniformity in the coding of routine services causes providers to lose confidence in both the carriers and the Medicare program. The absence of a national policy on the appropriate code to designate the routine level also increases carriers' difficulties in dealing with individual providers on coding problems.

Too Many Codes Are Available

Many carrier staff state that in their opinion physicians are often confused by the large number of CPT codes available to describe office and hospital visits (six and five respectively). Additionally, many respondents perceive a lack of meaningful distinction among the various CPT coding levels, particularly the "brief" and "limited" levels. This appears to be a major factor in accounting for differences in interpretation of "routine" and other visit codes.

Under most of the carriers' previous coding systems, there were fewer codes than under the present CPT system. Some of these former systems had codes termed "routine" for office and hospital visits. Carrier respondents indicate that many physicians preferred to use these codes almost exclusively rather than having to chose the "correct" code from among several. Many believe that physicians still prefer this manner of billing.

In consideration of these points, respondents representing 70 percent of the Medicare carriers feel that the number of codes for office and hospital visits should be reduced.

REIMBURSEMENT IS ALSO A FACTOR

While differences in interpretation of codes by carriers and providers account for most of the variations in coding of office and hospital visits, other factors also contribute.

Many carrier staff indicate that a number of physicians may seek to maximize reimbursement by billing a higher level code than appropriate for the service rendered. In numerous cases, this was substantiated by carriers' findings in postpayment review of physicians' claims. Several carriers suggested that this problem may be accelerating as Congress imposes measures, such as fee freezes, to control spiraling Medicare outlays.

Carriers also point out that the coding selection process which is used in the physician's office frequently includes consideration of the amount the carrier will reimburse for a billed service. Although code selection should be based solely on the type of service rendered, those who prepare the bills often match the physician's normal charge for an office or hospital visit to the code which pays the same amount, and bill accordingly.

The attitude expressed by several carrier representatives, including one medical director, supplied another example of the influence of reimbursement factors on coding. These persons noted that if physicians consistently bill just one code for established patient office visits and one for subsequent hospital care, over time the reimbursement "highs and lows will balance out."

One of the larger carriers explained that they urge physicians to use the appropriate codes, but they routinely accept the intermediate level code (90260) for daily hospital visits throughout the hospital stay. Carrier representatives acknowledge that the patient should be improving the closer he comes to the day of discharge. Thus, he should not require the more extensive services represented by code 90260 at the end of his stay. However, the carrier reasons that reimbursement is about the same using code 90260 for each day as it would be using the higher level codes at the beginning of the stay and the lower codes toward the end.

Other Factors Contribute to the Problem

Still other factors which could lead to variations in coding were mentioned by carrier personnel:

- Physicians may be reluctant to use the current CPT codes describing "brief" or "limited" visits out of concern that these terms imply inferior service.

- Many specialists believe they should bill the higher level codes because they are specialists, regardless of the actual service rendered.

- Some physicians, as well as some carrier staff, believe that the more *time* spent with the patient the higher the code that should be used. (The CPT already takes into consideration the time each service should take.)

- In the CPT booklet the definitions of code levels are in a different section than the codes themselves. Associating the two is somewhat inconvenient.

HCFA and the Congress Consider Solutions

Several activities are currently underway to address specific coding problems and their underlying causes.

In order to deal with providers who may be coding services inappropriately, HCFA has mandated that all carriers use prepayment screens for certain procedure codes. These screens detect instances of physicians billing for more than a specified number of a single procedure for one patient over a given period of time. When these cases are identified by the screening process, carriers must review all claims for medical necessity before making payment.

However, there are problems with this approach. The same screens apply to all carriers equally. They assume a uniformity in application and definition of codes which does not exist. As an example if HCFA required carriers to examine all claims for service code 90260 when over six per month are submitted, some carriers would have to examine most of these claims. This would be the case for carriers which consider 90260 the appropriate code for a "routine" hospital visit.

The Omnibus Budget Reconciliation Act of 1986 (OBRA) requires that the Secretary of HHS, by no later than July 1, 1989, "...group the procedure codes contained in any HCFA Common Procedure Coding System for payment purposes to minimize inappropriate increases in the intensity or volume of services provided as a result of coding distinctions which do not reflect substantial differences in the services rendered." If this requirement is applied to "subsequent hospital care" and "established patient office visits" much of the coding problem will be resolved. The HCFA, which is acting for the Secretary in this matter, has not yet decided whether these services will be included in the code grouping OBRA requires.

RECOMMENDATIONS

Consult with AMA to Reduce Number of Codes

Findings: Carriers report that physicians are sometimes confused by the number of codes available under CPT for office and hospital visits. Carrier staff also perceive a lack of mean-

ingful distinction among the various coding levels. Respondents representing 70 percent of all carriers believe fewer visit codes are necessary. Physicians may prefer to use just one code rather than chose the "correct" code from among several. Finally, some carriers accept billings from physicians who use only one code even when it is apparent that different level services were rendered. They rationalize that, for reimbursement purposes, "the highs and lows will balance out."

Recommendation: The HCFA should consult with the AMA to reduce the number of codes available under CPT for "established patient office visits" and "subsequent hospital care."

Impact: This would bring the coding system more in line with actual billing practices. It would also reduce the incidence of inappropriate coding, and its accompanying effect on reimbursement, by providing fewer choices and greater distinction between code levels.

HCFA Comments: The HCFA agrees with this recommendation and has been working on this problem for some time. Discussions focused on reducing the number of codes have recently taken place between HCFA and the AMA.

Consolidate Codes for Reimbursement Purposes

Findings: Bills are often prepared in physicians' offices by matching the physician's charge with the carrier's reimbursement schedule, rather than with the appropriate code for the service actually rendered. Carriers have noted instances of physicians using a higher level code than appropriate in order to increase reimbursement. Some carriers may be accepting a higher level of coding than appropriate for "routine" services. The HCFA is required by OBRA to group (combine) procedure codes for payment purposes in situations where distinctions between levels are unclear.

Recommendation: Concurrent with seeking to reduce the number of codes available, HCFA should pursue consolidation of visit codes for payment purposes.

Impact: This would reduce the impact that inappropriate coding has on Medicare outlays and fulfill the intent of OBRA.

HCFA Comments: The HCFA agrees with this recommendation. A letter was recently sent from HCFA to the AMA outlining potential coding consolidations.

Define "routine" Level

Findings: There are large variations in usage of CPT codes for "established patient office visits" and "subsequent hospital care." These variations are most evident where the "routine" level of service is being billed under a number of different codes. The HCFA has designated the codes it believes "most correct" for routine services but has not promulgated this information nationally.

Recommendation: The HCFA should inform all carriers and providers of the codes it considers "most correct" for routine office and hospital visits and then assure its instructions are applied consistently.

Impact: Consistency of interpretation from carrier to carrier will improve the credibility of the coding system. Consistency will also strengthen carriers' positions in dealing with coding problems with individual providers. Further, it will allow HCFA to better use payment data by visit codes for trend analysis and policy making in such areas as fee schedules.

97-397 O - 89 - 5

HCFA Comments: The HCFA agrees with this recommendation. A HCFA representative recently met with an AMA Ad Hoc Committee on Visits and Levels of Service. The meeting focused on the need for uniform understandings by Medicare carriers and the physician community regarding what codes describe "routine" visits and consultations, as well as how codes should be used by physicians in the various specialty fields.

Consult with AMA on Other Changes

Findings: Carriers report that some physicians may be reluctant to code their claims at the CPT levels termed "minimal," "brief" and "limited" due to the negative implications of these terms. Respondents also point out that the present format of the CPT book makes it inconvenient to associate the description of the level of service with the corresponding code.

Recommendation: The HCFA should discuss with AMA changing the terminology used to describe services so as to neutralize its effect on coding choice. Easier association of code *level* with the codes, at least for higher volume areas such as physician visits, should also be discussed with AMA.

Impact: These changes would eliminate two factors which appear to inappropriately bias the code-selection process.

HCFA Comments: The HCFA agrees with the recommendation. At the recent meeting between a HCFA representative and the AMA Ad Hoc Committee on Visits and Levels of Service, the need to avoid terminology that has negative connotations in the narrative descriptions of certain codes was discussed.

Educate Providers on Proper Coding

Findings: Carriers report that physician specialists often feel they should bill the higher level CPT codes simply because they are specialists. Some physicians believe the more time they spend with a patient the higher the code level they should bill. The current CPT system *already* takes into consideration the time and level of skill needed to perform various levels of services. These should not be factored in again by the physician.

Recommendation: The HCFA, along with the carriers, should better inform physicians of HCFA's interpretation of proper use of CPT codes.

Impact: Better physician understanding of the CPT system will help to reduce inappropriate coding of services.

HCFA Comments: The HCFA agrees with the recommendation. This concern was also discussed at the recent meeting between a HCFA representative and the AMA Ad Hoc Committee on Visits and Levels of Service.

APPENDIX A

Data Sources

Part B Medicare Annual Data (BMAD), Procedures File, 1984, 1985, and 1986

Carrier Annual Management Reports as Submitted to HCFA

AMA's Physicians' Current Procedural Terminology (4th edition), 1984-1988

Physician Payment Review Commission's *1988 Report* to Congress

HCFA Common Procedures Coding System, Conversion/Implementation Manual and User Guide

Office of Technology Assessment report: *Payment for Physician Services* (1986)

Various HCFA/Carrier policy memoranda and guidelines

APPENDIX B

Carrier Billing Frequencies for Office and Hospital Visits
(Computed from 1986 BMAD, Procedures File)

ESTABLISHED PATIENT OFFICE VISITS

(PERCENTAGE OF TOTAL SERVICE FREQUENCY WITHIN 90030-90 CODE RANGE, 1986)

NUMBER	CARRIER NAME		% 90030	% 90040	% 90050	% 90060	% 90070	% 90080
00510	BLUE SHIELD-AL							
00540	BLUE SHIELD-AK							
00580	BLUE SHIELD-AZ							
00582	BLUE SHIELD-AR	CLM						
00610	BLUE SHIELD-CA	NORTHERN						
00620	BLUE SHIELD-CA							
00670	BLUE SHIELD-CO							
00680	BLUE SHIELD-CT	GHS						
00730	BLUE SHIELD-DE							
00741	MEDICAL SERVICE-DC							
00750	BLUE SHIELD-FL	SER.-IL						
00760	BLUE SHIELD-GA							
00780	BLUE SHIELD-ID							
00810	BLUE SHIELD-IL							
00820	BLUE SHIELD-IN							
00840	BLUE SHIELD-KS							
00850	BLUE SHIELD-KY							
00870	BLUE SHIELD-LA							
00880	BLUE SHIELD-ME							
00900	BLUE SHIELD-MD							
00910	BLUE SHIELD-MA							
00920	BLUE SHIELD-MI							
00930	BLUE SHIELD-MN	(MN,VT)						
00940	BLUE SHIELD-MS	(WESTERN)						
00950	EMPIRE BLUE SHIELD	(NYC)						
00960	BLUE SHIELD-MO	SD						
00965	BLUE SHIELD-PA							
00970	BLUE SHIELD-NE							
00980	BLUE SHIELD-NJ							
00990	BLUE SHIELD-NM							
00910	BLUE SHIELD-NY							
00930	BLUE SHIELD-VT							
01121	PHY. SER.-WI							
00972	PUERTO RICO-PS							
01020	AETNA-AK							
01030	AETNA-AZ							
01120	AETNA-NJ							
01290	AETNA-NV							
01340	AETNA-NM							
01370	AETNA-OK							
01390	AETNA-OR							
02050	TRANSAMERICA-CA							
05130	EQUITABLE-ID							
05440	EQUICORE-TN							
05530	EQUICORE-WY							
10071	ERS							
10230	TRAVELERS-CT							
10240	TRAVELERS-MN							
10250	TRAVELERS-MS							
10490	TRAVELERS-VA							
11260	GEN. AM. LIFE.-MO							
13110	PRUDENTIAL-GA							
13310	PRUDENTIAL-NJ							
13340	PRUDENTIAL-NC							
14330	GHI-NY							
16360	NATIONWIDE OH							
16510	NATIONWIDE WV							
21200	BLUE SHIELD-NE							
	AVERAGE %		82	15	41	31	84	84
	1985 AVERAGE %		83	10	41	30	83	83
	HIGHEST %		10	44	77	84	17	87
	LOWEST %		00	01	03	03	01	01
	AVERAGE ALLOWED		$11.54	$15.20	$18.34	$22.68	$29.10	$42.35

* HCFA indicates data for Blue Shield Florida and Blue Shield Indiana may not be accurate. Accordingly, figures from these carriers were not used for highest or lowest columns.

Note: All figures of less than 12 are represented by "00".

SUBSEQUENT HOSPITAL CARE

PERCENTAGE OF TOTAL SERVICE FREQUENCY WITHIN 90240-99 CODE RANGE, 1984

CARRIER NUMBER	NAME	% 90240	% 90250	% 90260	% 90270	% 90280
00510	BLUE SHIELD-AL	11	37			
00520	BLUE SHIELD-AR	10	40			
00530	BLUE SHIELD-AR (LA)	08	40			
00542	BLUE SHIELD-CA (NORTHERN)	08	40			
00550	BLUE SHIELD-CO	21	37			
00570	BLUE SHIELD-FA (SE)	16	41			
00580	BLUE SHIELD-FA (SC)	16	41			
00590	BLUE SHIELD-FL	16	41			
00621	HEALTH CARE SER.-IL	24	38			
00630	BLUE SHIELD-IN	24	38			
00640	BLUE SHIELD-IA	08	40			
00648	BLUE SHIELD-KS	08	40			
00650	BLUE SHIELD-KS	08	40			
00660	BLUE SHIELD-KY	08	40			
00690	BLUE SHIELD-MO	21	38			
00700	BLUE SHIELD-NA	08	40			
00710	BLUE SHIELD-NI	08	40			
00720	BLUE SHIELD-NM	08	40			
00740	BLUE SHIELD-NO (OK)	08	40			
00751	BLUE SHIELD-NT	33	37			
00780	BLUE SHIELD-NA (NH,VT)	08	40			
00801	BLUE SHIELD-NY (WESTERN)	17	43			
00803	EMPIRE BLUE SHIELD (NYC)	08	40			
00820	BLUE SHIELD-NO,SO	08	40			
00845	BLUE SHIELD-PA	14	37			
00870	BLUE SHIELD-RI	14	43			
00880	BLUE SHIELD-SC	08	40			
00900	BLUE SHIELD-TX	08	40			
00910	BLUE SHIELD-VT	08	40			
00930	WA PHY. SER.	11	43			
00951	PHY. SER.-WI	08	40			
00973	PUERTO RICO-BS	08	40			
01020	AETNA-AK	11	43			
01030	AETNA-AZ	08	40			
01120	AETNA-HI	08	40			
01290	AETNA-NV	08	40			
01360	AETNA-NM	11	43			
01370	AETNA-OK	11	43			
01380	AETNA-OR	08	40			
02050	TRANSAMERICA-CA	02	31			
05130	EQUITABLE-ID	05	31			
05440	EQUICORE-TN	16	32			
05530	EQUICORE-WY	10	32			
10071	BCS	10	32			
10230	TRAVELERS-CT	05	28			
10240	TRAVELERS-AR	15	47			
10250	TRAVELERS-MS	11	39			
10490	TRAVELERS-VA	07	33			
11260	GEN. AM. LIFE.-MO	10	44			
13110	PRUDENTIAL-GA	05	37			
13310	PRUDENTIAL-NJ	04	48			
13340	PRUDENTIAL-NC	10	46			
14330	BHI-WY	01	46			
16360	NATIONWIDE OH	16	41			
16510	NATIONWIDE WV	05	41			
21200	BLUE SHIELD-ME	05	47			
	AVERAGE %	16	39	34	08	03
	1983 AVERAGE %	18	39	33	07	02
	HIGHEST %	50	94	05	23	10
	LOWEST %	01	06	01	00	00
	AVERAGE ALLOWED	$17.61	$21.33	$26.17	$29.61	$34.91

* HCFA indicates data for Blue Shield Florida and Blue Shield Indiana may not be accurate. Accordingly, figures from these carriers were not used for highest or lowest % columns.

Note: All figures of less than 12 are represented by "00".

APPENDIX C

Request for HCFA Guidance on Coding "Routine" Visits

April 22, 1985

Refer to: DPO-R6-3:JD
UR-PJB

Health Care Financing Administration
Region VI - Dallas

HCPCS Implementation and Postpayment Utilization Review for Upcoding

Phillip Nathanson, Director
Bureau of Health Standards and Quality

Prior to the implementation of HCPCS, we looked on codes 90040 (routine follow-up office visit) and 90240 (routine hospital visit) as the codes for office and hospital visit services we would normally expect a physician to provide most of the time. If, in reviewing a physician through postpayment utilization review, we found a physician who was billing the Medicare program for a substantially larger number of higher level service (e.g., 90050) than the routine service (i.e., 90040), we considered the physician's practice as being a potential "upcoding" situation. However, with the implementation of HCPCS, we are now uncertain as to what the routine office and hospital visit codes are. (For example: Would the routine office visit code now (under HCPCS) be 90040, 90050, or would it depend on what the CRVS to HCPCS code pricing conversion was? If the latter, what would be considered the routine code for an office visit if the CRVS 90040 charge data was used to price both the 90040 and 90050 HCPCS codes?)

Since the implementation of HCPCS, our position to the carriers in our region has been that HCPCS codes 90040 and 90240 are to be considered the routine office visit and hospital visit codes, respectively, for upcoding consideration. We have taken this position because in some cases allowing a physician who was using 90040/90240 in the past as his routine codes to use 90050/90250 now under HCPCS will result in a higher Medicare allowance. For instance, this will occur if the carrier used 90040 to price 90040 and 90050 to price 90050. However, we have recently seen Medicare newsletters that Prudential and General American Life have sent out to their physician communities which indicate that they are considering 90050 and 90250 as the routine codes. (Copies of these newsletters are attached for your reference.) We are sure that Prudential and General American Life took their positions based on the CPT-4 definition of "limited level of service" which does seem to support the use of 90050 and 90250 as routine service codes.

We would appreciate receiving your comments as to which HCPCS codes should be considered the routine codes for postpayment upcoding review purposes. We plan to hold a utilization review work group meeting for our carriers in the near future and therefore would appreciate receiving your response by May 15, 1985.

If we can provide you with any additional information on this matter, please contact John Delaney at FTS 729-6401.

M. J. Christenberry
Program Director
Policy and Operations

APPENDIX D

HCFA Advice on Coding Routine Visits

SEP 1 1985

Director
Division of Data Administration, OIRM, BDMS

HCPCS Implementation and Post Payment Utilization Review for Upcoding

Mr. J. Christenberry, Program Director
Policy and Operations
Region VI - Dallas

Your request to HSQB inquiring which HCPCS codes should be considered the routine codes for post payment upcoding review purposes has been referred to this office. This response was coordinated with the Bureau of Eligibility, Reimbursement and Coverage (BERC).

As you know, there currently is no uniform national translation table for carriers to follow in converting formerly used visit codes to HCPCS. Also, as you have pointed out, the definitions of the levels of services in the American Medical Association's Current Procedural Terminology (CPT) could lead to a conclusion that CPT/HCPCS codes 90050 and 90250 represent the routine follow-up visit services, rather than codes 90040 and 90240. It seems to us, therefore, that which HCPCS visit codes are for the routine services depends primarily on what a carrier's charge data conversion was. Conversely, whether it used the appropriate charge data in establishing the reasonable charge screens for the HCPCS visit codes depends on which of them it, and the physicians in its service area, consider to be the ones for the routine services.

Outlined below, are some of the alternatives carriers may have followed in this regard, and our comments:

1. If a carrier's charge data conversion was from 1964 CRVS codes 9004/9024 to HCPCS codes 90040/90240, then the changes in the relative frequency of services reported under the latter codes are as you have indicated, the appropriate basis for identifying possible "upcoding" situations. In this instance, it also seems to us that charge data previously collected under 1964 CRVS code 9003 (brief follow-up office visit) would be used to establish the reasonable charge screens for HCPCS code 90030 (minimal service).

2. If a carrier has identified HCPCS codes 90050/90250 as the routine visit services, then the reasonable charges screens for these codes should have been based on data from charges previously made by physicians under 1964 CRVS codes 9004/9024. As you have pointed out, there would otherwise be an unwarranted escalation in the charges allowed for routine visits. Consistent with the above, we think that in this alternative, the charge data for 1964 CRVS code 9003 (brief follow-up visit) should be used to establish the reasonable charge screens for HCPCS code 90040 (brief service) and possible also for HCPCS code 90030 (minimal service). In the latter event, HCPCS code 90040 should be announced to

physicians as being equivalent to 1964 CRVS code 9003, with the expectation that lower charges will be made for code 90030. Alternatively, the instructions in Medicare Carriers Manual section 5205 (Charges for Rare or Unusual Procedures) should be followed in establishing a lower reasonable charge screen for HCPCS code 90030. Further, we would expect that charge data for the 1964 CRVS codes 9005, 9006, 9007, 9025, and 9027, etc., would be used to establish the reasonable charge screens for the HCPCS codes for more extensive follow-up visits.

3. If a carrier has used charge data for 1964 CRVS codes 9004/9024 to price services under the 90040 and 90050/90240 and 90250 HCPCS codes it has, in effect, identified a set of two HCPCS office visit codes and a set of two HCPCS hospital visit codes, with each set describing a single, i.e., routine service. In such a case the relative frequency of services under these sets of codes should be used to identify possible "upcoding" situations.

We prefer that the carriers use the second alternative because our medical consultant thinks this may be most "correct" translation. Also, we emphasize that it is important for each carrier to make sure through its professional relations activities/newsletters that physicians in its service area know what coding and charge data conversions were made, and which HCPCS code(s) should be used to describe what were previously called "brief" and routine etc., visits.

Please refer any questions to Harry L. Savitt at FTS 987-6322.

Thomas T. McCloskey

ATTACHMENT 5

THE EQUITABLE
MEDICARE ADMINISTRATION
P.O. Box 1465
Nashville, Tennessee 37202

September 26, 1986

Douglas Marshall
Office of Inspector General
Office of Analysis & Inspections
Suite 1402, 101 Marietta Tower
Atlanta, Georgia 30323

Dear Mr. Marshall:

During your visit of September 2, 1986, you were provided with copies of the initial letters mailed to 129 general practitioners who were involved in our upcoding project. As you know, we are in the process of conducting a subsequent review on the 13 out of the initial 129 general practitioners who failed to demonstrate an appreciable change in their upcoding patterns within one year of receiving notification.

Enclosed is a copy of a recent response that we received from one of the 13 general practitioners who was recontacted. In my opinion, this response further supports the need for upcoding to be addressed on a national level. There will always be a few physicians who cannot or will not grasp the importance of proper coding.

If I can provide any further information to assist you in your national study on upcoding, please feel free to give me a call.

Sincerely,

Judy Webb

Judy Webb, Supervisor
Program Evaluation

TO: Judy Webb, Supervisor
Program Evaluation

DATED: May 16, 1988

SUBJECT: Special Study - Ambulatory Surgical Centers

Ambulatory Surgical Centers (ASCs) were selected for special study because during previous integrity reviews involving ASCs, we noted some problems which had the potential of being widespread. The purpose of this study was to determine whether ASCs were billing in accordance with established guidelines regarding covered surgical procedures.

The Omnibus Reconciliation Act of 1980, Section 934 of Public Law 96-499, authorized Medicare Part B coverage for facility services furnished in connection with certain surgical procedures performed in a HCFA approved ASC.

An ASC is a distinct entity that operates exclusively for the purpose of furnishing outpatient surgical services. Surgical procedures covered under this provision are limited to those as specified by Congress which although

appropriately performed in an inpatient hospital setting, may also be performed safely in certain ambulatory settings.

ASC facility services are reimbursed by means of a prospectively determined rate. The surgical procedures are classified into five groups, all procedures within the same payment group are reimbursed at a single rate. Prior to July 1, 1987, Medicare provided 100% reimbursement for the facility fees associated with approved surgical procedures on an assigned basis. In accordance with the Omnibus Reconciliation Act of 1986, facility services furnished July 1, 1987 forward are paid at 80%, subject to co-insurance and deductible. For services rendered prior to April 1, 1988, Medicare pays 100% of the physician's reasonable charge if the physician accepts assignment for services. Effective April 1, 1988, ASC physician services are paid at 80%, subject to co-insurance and deductible.

Because only certain surgical procedures are approved for an ASC, it is imperative that both the physician's charge and the facility fee be reported under the appropriate procedure code. Consequently, the procedure codes billed by both parties should match and should represent the actual surgery performed.

When we began our study, there were 15 ASCs certified as Medicare Part B providers in Tennessee. Postpayment data covering approximately one and a half years was retrieved for each one. A cursory review was conducted of each practice. Claims for facility fees were then compared to the surgeons' claims. We found it helpful to compare the anesthesiologists' claims who should have also used the same surgical procedure code. Through this screening process, we identified major billing discrepancies for three ASCs. We therefore focused our study on these three providers. Following is a summary of our findings.

CASE #1

Both the physician and facility fees are billed out of the same office. During our review of claims, we noted that on some, the procedure code did not correspond with the description shown on the claim. For the description, the claims indicated yag laser. Until May 21, 1987, yag laser surgery (descission of secondary membraneous cataract by use of laser) was not approved for an ASC. The correct CPT procedure code for yag laser is 66821; however, the procedure code contained on the claims was 66830. The procedure defined by CPT code 66830 is approved for an ASC.

A contact was made with r and it was verified that the surgeries, as billed above, did actually involve the yag laser technique. Both the physician and facility fees had been billed under an incorrect procedure code. Since Medicare's payment was based on the procedure code billed, an overpayment was assessed in the amount of $18,480.03 for the facility fees. The physicians' claims were not overpaid because 80% of the reasonable charge for the correct procedure was greater than 100% allowance for the incorrect procedure.

This ASC was educated concerning the use of proper procedure codes and the overpayment was recovered in full.

CASE # 2

Numerous claims were noted where the procedure code used to bill the ASC facility fee did not match the procedure code used for the surgeon's charge. In these instances, the surgeries reported for the physician's charges were not ASC approved and the surgeries reported for the connected facility fees were ASC approved.

Research of these claims revealed that c billed the surgeon's fees under the appropriate procedure code which represented

the entire surgery. The facility fees were billed under an ASC approved procedure code that represented only an incidental portion of the entire surgery. For example, for a labyrinthotomy with mastoidectomy and shunt, the surgeon's fee was billed using CPT code 69806. The facility fee was billed under CPT code 69501, "simple" mastoidectomy. Procedure code 69806 is not approved for an ASC and procedure code 69501 is.

Based on the incorrect billings by , an overpayment of $10,333.00 has been calculated. Recovery measures have been taken and this group has been educated and cautioned accordingly. Our assessment of this case was supported by the Regional Office.

CASE # 3

As before, we found numerous instances of where the procedure codes used to report the facility fees differed from those of the surgeons'. Procedures billed by the surgeons were not approved for an ASC but the codes billed for the facility fees were.

The surgeries actually performed were:

66820- Discission of secondary membraneous cataract (after cataract) and/or anterior hyaloid; incisional technique (Ziegler or Wheeler knife)

66821- laser surgery (one or more stages)

The associated facility fees were billed under one of the following:

66801- Discission of lens capsule; incisional technique (needling of lens), subsequent

66830- Removal of secondary membraneous cataract (after cataract), with corneoscleral section, with or without iridectomy (iridocapsultomy, iridocapsulectomy)

M0050- Ambulatory Surgical Center
Group I

This particular case is being referred to the Office of Inspector General, per their instructions, for consideration as a civil money penalty (CMP) candidate.

Approximately $77,000.00 has been overpaid to Center as a result of the erroneous billings described above.

During our review of this group, another problem was identified concerning the billing of multiple surgeries. When multiple surgeries are provided during the same operative session, the first major procedure may be reported as listed. The secondary or lesser procedure(s) should be identified by adding modifier '51' to the usual procedure code(s). In doing so, Medicare provides full reimbursement for the major surgery and half on the secondary procedures(s).

Center submitted electronic claims for multiple surgeries without adding modifier '51' to the secondary procedure(s). This caused the secondary procedures to be paid at 100% of the applicable rate instead of 50%. Although this billing problem has since been resolved, we estimate that an additional $2,000 has been overpaid to r on the multiple surgeries.

In summary, we feel that our special study on ASCs has proven worthwhile. We were able to identify over $100,000.00 in overpayments in addition to preventing other future erroneous payments. The problems detected through our study are such that would not normally be recognized through the pre-payment process. It is for this reason that we recommend that all carriers conduct annual post-payment audits of ASC claim submissions. We believe these efforts and the results thereof would hold national significance.

With the continuing need to contain spiraling medical expenses, we expect that the number of ASCs and outpatient surgeries will increase over the next few years as an alternative to hospitalization. There is a potential for future misrepresentation since the associated facility services are reimbursed only for approved surgical procedures.

Advances in medical science make additions or revisions of the list of covered ASC procedures necessary to keep pace with changing procedures. The Omnibus Reconciliation Act of 1986 provides that as of July 1, 1987, and annually thereafter, the Secretary must review and update ASC payment rates; in addition, the list of procedures must be reviewed and updated every 2 years after April 21, 1987. Therefore, as more procedures are added to the ASC covered list, there may eventually be a decline in the need for conducting ASC audits. In the interim, annual reviews of ASCs deserve consideration as an effective tool for controlling waste and abuse.

Bonnie Woodard
Program Evaluation Specialist

STATEMENT OF SALLY WOOD

Senator HARKIN. Thank you very much, Mr. Lifson. Sally Wood, vice president of government affairs, Blue Cross and Blue Shield of Iowa.

Ms. WOOD. Thank you, Mr. Chairman. I think my colleagues have done a good job summarizing the financial picture. I would like to say just a little bit about who we are and what we do in Iowa as a Medicare contractor. As contractors go, we are a middle-sized contractor in Iowa. We have projected that we will process about 6.8 million claims this next year and we will pay out $1.1 billion in benefits for Medicare beneficiaries.

In the context of the payment safeguard activities, we have heard a lot of discussion about what those are, how we administer them, and particularly, I think, what makes a good contractor or a bad contractor and there are a number of things about that.

One of the comments I would like to touch on in particular is in the fraud and abuse area. It is very difficult to detect the kinds of fraud and abuse that we have been talking about this morning in a vacuum. There has to be a partnership between the parties affected. The more closely contractors work together, the more closely we work with the Inspector General's Office as well as with some HCFA people day in and day out, the more effective we can be in producing the evidence that is necessary to bring those areas up for some type of review and ultimately sanctions if that is warranted.

I think it is also important to keep this in context, as far as the contractor's business goes. There are big potential dollars involved, but administratively that is a very small part of who we are and what we do. We have statutory regulations that we must comply

with as far as claims and payments go. We must be responsive to beneficiaries and providers in timely and accurate claims payment and in timely and accurate response to telephone inquiries and written inquiries. That is basically the bread and butter of what we do day in and day out.

In the payment safeguard area, we give particular emphasis to educational activities and in that area I believe that we are a very valuable service to providers in particular. Providers have some of the same difficulties that we, as contractors, encounter and they have turnover of staffs. They have to educate their own people in the provisions of the Medicare program. So when, in fact, maybe honest mistakes are made or we discover a pattern of administration at the contractor level that is not acceptable, a tremendous amount of time and effort is spent educating the providers about what is appropriate and we give them time to correct those mistakes. So the cases that ultimately arrive at the inspector general's doorstep are really those cases that are the most flagrant abuses and they are not the representative example of what happens by and large, day in and day out, by the providers.

EFFECT OF REDUCING PROGRAM SAFEGUARD FUNDS

If those payment safeguard funds are eliminated or drastically reduced, not only would we expose the program to those additional costs, but we would also not be able to provide a real valuable service right now to the providers as far as the ongoing education. In that regard, I think there is a very strong partnership that would be weakened by not having the wherewithal to actually perform those educational activities.

In one of the areas that a contractor is responsible for, we perform field audits, as Mr. Horton mentioned, we go out to the provider's location, we review their records and we detect whether the charges that are being applied to the Medicare Program are appropriate.

In one case where we were on site, we discovered the pattern of a physician referring patients to receive services from a home health agency in which that physician had a major ownership. That is not appropriate. The rules are very clear on how that is to be done and dealt with. We were able to produce savings for the Medicare Program from that situation.

Not having adequate payment safeguard funds, I think, will be sending a message to the contractors, and because of the publicity it could be interpreted that there is virtually an open cash drawer and we will be exposed to even potentially greater outlays of the Medicare trust funds than what we might have already projected here.

Finally, I think just a brief comment on the contractor's ability to handle their multiple responsibilities in these areas. I would venture to say that I think there is some middle ground in dealing with the inspector general as well as with HCFA. I think contractors are very interested in responding to directives and leadership from those bodies. I think it does not serve a contractor's long-term interest to become an adversary of those agencies and so I think

there is a lot of intentional effort to cooperate and to build and strengthen the programs that are in place.

PREPARED STATEMENT

The staffing implications of a reduction in funds are very real because these are by and large professional people, accountants, registered nurses, that administer the payment safeguard aspects of the program. Those people will leave as a result of reduction in funds or even the rumors of reductions will produce an increased amount of attrition. If, in fact, the funding is reinstated in 1991, it will be difficult to recruit the level of people that we need to build the program back up, so it is not a matter of turning the faucet on and off. There will be a very long-term effect, so that I think that is an important consideration and we do request that the funding remain adequate, that it is stable and that it remain predictable from one year to the next. Thank you, Mr. Chairman.

[The statement follows:]

STATEMENT OF SALLY T. WOOD

Chairman Harkin and members of the subcommittee, I am Sally T. Wood, Vice President of Government Programs for Blue Cross and Blue Shield of Iowa. I appreciate this opportunity to discuss our views on the impact of the proposed Medicare administrative funding reductions, particularly in the area of payment safeguards.

Blue Cross and Blue Shield of Iowa have provided more than twenty years of dedicated service to the Medicare program, the Medicare beneficiaries of Iowa and the Iowa health care provider community. Two years ago, the Health Care Financing Administration (HCFA) asked us to expand our role and serve as a regional processor for home health claims. In that capacity, we now service over 1,000 home health agencies and hospices doing business in 42 states. For fiscal year 1989, Blue Cross and Blue Shield of Iowa expect to process over 6.8 million claims and pay out over $1.1 billion in benefits on behalf of Medicare beneficiaries.

As Medicare contractors, we are responsible for performing a vast number of day-to-day services which ensure that payments are made on time and accurately, inquiries from beneficiaries and health care providers are answered properly and professionally, and services for which Medicare pays are medically necessary and appropriate. In addition, we provide outreach and educational activities to inform Iowa's health care community and Medicare beneficiaries of complex legislative and administrative changes in how the Medicare program pays for specific services as well as changes in what services are covered. For example, acting under guidance provided by the Health Care Financing Administration, Medicare

contractors have carried out numerous recent changes in reimbursement rules for hospitals, clinical labs, home health services, physician services and other providers.

The partnership between the federal government and its Medicare contractors has served the program and its benficiaries well over the last two decades. Overall, contractor expenses represent only about 1.5 percent of the Medicare budget, an enviable record of efficiency for any federal program. The payment safeguard activities performed by contractors annually result in savings to the Medicare trust funds which far exceed the total cost to the federal government of the entire range of contractor activities.

We have an important obligation to Medicare's beneficiaries to see that their dollars are paying for health care services prudently and appropriately. Indeed, this obligation is recognized in the stringent performance standards that we are held to by HCFA. In total, contractors are accountable to the federal government on 129 separate performance measures, 30 of which relate to providing tangible evidence of our efforts to protect the Medicare trust funds from excessive or inappropriate payments for health care services.

Resources to administer this complex program are appropriated by Congress and allocated by HCFA each year. HCFA also establishes the allocation of resources among contractor functions and, ultimately, among each of its contractors. For the current year, approximately one-quarter of the funds appropriated by Congress for contractor operations are dedicated to payment safeguards activities.

The FY 1990 budget submitted by former President Reagan on January 9 proposed a 12 percent cut in the overall funding level for basic contractor tasks. This budget ignores the facts that Medicare claims volume is projected to grow by 12 percent in 1990 and inflation will be up by another 4 percent. Although it is not clear how President Bush's proposal will affect this program, it appears that this budget reduces the Medicare contractor FY 1990 funding level below the Reagan budget amount.

We at Blue Cross and Blue Shield of Iowa are concerned about providing the best possible service to the Medicare beneficiaries as well as efficiently using the administrative funding allocated by HCFA. We are deeply concerned that the proposed budget for fiscal year 1990 contains a 35 percent reduction in funding for payment safeguard activities. Payment safeguard activities fall into three basic functional areas: financial auditing, review of claims for medical necessity and appropriateness of services, and detection of instances where other insurers are responsible for the payment of claims before Medicare pays.

All of these payment safeguard activities are essential to the integrity of the Medicare program and result in <u>real</u>, documented savings to the trust funds, Medicare beneficiaries and the American taxpayers. In 1988 alone, these payment safeguards resulted in just over $3 billion in savings and could, no doubt, return even more with steady and adequate funding in this area. In Iowa, we reported approximately $57 million in savings to the Medicare program last year, a ratio of 10:1 for the dollars invested in payment safeguard activities.

It is important to understand that the overwhelming majority of Medicare claims are submitted for legitimate services by conscientious health care providers and beneficiaries for essential medical services covered by Medicare. However, Medicare is a very complex program involving the payment of nearly $100 billion for health care services under many separate payment policies, limits on allowable costs, and conditions of coverage. In a program this large and complex, much of what is required in reviewing claims is needed simply to make sure that the payment rules are being properly observed. Just as important, for those who intend to take advantage of the system by concealing costs for which Medicare is not responsible or billing for services for which Medicare should not pay, payment safeguard activities are the best available means we have to detect wrongful practices.

MEDICAL REVIEW

Contractors routinely review Medicare claims to make sure that the services provided meet criteria for medical necessity and appropriateness for the patient's condition. In addition to the financial savings that result from these activities, we are convinced that there is an important "sentinel effect" of deterring the submission of claims for unnecessary services once the limits of Medicare reimbursement rules are understood by health care providers.

In addition, medical review safeguards sometimes lead to suspected instances of wrongdoing which are referred by us for further investigation. Over the past 18 months, Blue Cross and Blue Shield of Iowa has referred 76 cases to the Office of the Inspector General. Over 2,100 claims were researched and

evaluated in order to produce the 76 referrals. Examples of the problems which our reviewers uncovered include:

- o services billed to Medicare but never provided to the patient;
- o patients admitted to a health care facility as Medicare-covered when not eligible;
- o double-billings and inflated billings;
- o home visits billed for patients residing in a nursing home;
- o physicians paid a fee for making referrals or signing a plan of treatment and other alleged kickback schemes;

Many of these cases require months of meticulous review in order to detect potential fraud or abuse. In the past, the actions taken by the Inspector General in some of these cases have resulted in financial sanctions or suspensions of providers from the Medicare program.

Any reduction in funding would immediately have an adverse impact on the highly skilled staff who carry out these medical review responsibilities. In Iowa, this involves just over 100 individuals who are fully trained in Medicare's complex payment rules.

Should the program regain its funding the following fiscal year, we would incur a lengthy recruiting and training period. Since no new cases would have been developed in 1990, this work would have to start again in 1991. The likely results from that effort would not occur until 1992.

AUDIT AND REIMBURSEMENT

In addition to our medical review activities, one of the major responsibilities of a contractor is to audit the cost reports filed by institutional providers annually. At Blue Cross and Blue Shield of Iowa, we employ about 30 people who go out to the providers and perform field audit. Field audits are the hands-on, in-depth reviews done on selected institutions reporting costs to Medicare. The 1990 Reagan budget does not provide funds for field audits. This means that the Medicare program stands to lose hundreds of millions of dollars that would have been recovered as a result of scrutinizing costs reported to Medicare for reimbursement.

In fiscal year 1989, Blue Cross and Blue Shield of Iowa plan to spend $1.5 million on field audits and are expected to recover $24 million dollars for the Medicare program. This compares favorably with overall returns from contractors nationwide. If there are no field audits, then contractors can only review a provider's annual cost report to detect mathematical errors. This is comparable to the Internal Revenue Service only looking at submitted tax returns without having access to supporting documents.

Field audits give the Medicare contractor an opportunity to look at supporting documents and get way beyond simple mathematical mistakes. For example, we find costs claimed that are not reimbursable by Medicare such as advertising costs (TV/radio/newspaper ads) which are sometimes buried in miscellaneous administrative costs. We have also identified instances where services were provided that are simply not

covered by Medicare, such as providing physical therapy to a comatose patient.

This year in Iowa, we are planning 422 field audits of the 930 cost reports that we expect to receive this year for Medicare payments. If there were no field audits to validate the accuracy of the information supplied on the annual provider cost reports, then the future payment amounts could be questionable. HCFA relies on the accuracy of the audited cost reports when developing alternate payment methodologies, services such as ambulatory surgery and outpatient radiology. Lack of reliable data to develop these payment methodologies would almost certainly result in consistent overpayments to these providers.

The payment safeguard activities are vital to the long-term continuity of the program. Disruption in funding the field audits for one year has a detrimental impact that will be felt for the subsequent two year period. The on again, off again approach to funding undermines the ongoing provider education efforts and recovery of funds.

For example, the fully trained auditor requires a minimum of two years experience in working with a variety of providers and their cost reports. The auditors we hire in 1989 will be the source of strength for the 1991 audits. Retaining our current audit staff is an increasing problem with the talk which has already begun on the Administration's proposed funding cuts. We project that our current attrition level of 10 percent could climb to 25 percent this year just with the potential of deep cuts in this area. Another painful reality is that we would lose our best auditors because they have the

mostmarketable skills. To make matters worse, these talented individuals often secure their next positions in consulting organizations that advise those who are looking for ways to maximize their Medicare reimbursement. Therefore, reducing the 1990 funding will reduce our ability to meet HCFA's expectations for 1992 and beyond.

MEDICARE SECONDARY PAYER

The third, and final, payment safeguard activity is Medicare Secondary Payer (MSP). The purpose of this payment safeguard is to ensure that Medicare benefit payments are not made for services provided to Medicare beneficiaries who have insurance coverage with other payers that are primary to Medicare. Identifying these cases where other insurers should pay the bills before Medicare is highly cost-effective. With about 12 staff in this area, the Blue Cross and Blue Shield of Iowa MSP unit saved $17.7 million in fiscal year 1988 compared to an administrative budget of $589,000. This represents a ratio of $30.00 saved for every $1.00 spent.

MSP is a very complex provision of the Medicare program and the need for continuing education is very real. These outreach efforts as well as the enforcement activities are essential to carrying out federal legislation that defines when Medicare is responsible for paying health bills.

CONCLUSION

In summary, we believe that a substantial reduction in any one functional area jeopardizes our ability to serve your constituents well and exposes the Medicare trust fund to

unnecessary risks of excessive and inappropriate payment. While we are very concerned about the deep cuts proposed for payment safeguards activities, we are also seriously concerned about adequate funding for other core functions such as processing Medicare claims on time and accurately and responding to the growing numbers of beneficiary and provider inquiries by telephone and letters. Indeed, an adequately funded claims function also achieves savings through its review activities and is the basis for further safeguard actions.

Our ability to provide quality service to Medicare's beneficiaries requires a funding level that keeps pace with the 12 percent growth in the volume of claims that the program expects to receive next year and is sufficient to accomplish the complex tasks related to implementing legislative and administrative changes.

We also recognize that Congress has been working hard to restrain unnecessary Medicare cost growth, and we sincerely appreciate the importance you are placing on payment safeguard activities which are an essential part of that effort.

Adequate, stable, and predictable funding for the full range of Medicare contractor responsibilities is a sound investment, one of the best the federal government makes every year. As a Medicare contractor for over twenty years, we at Blue Cross and Blue Shield of Iowa are proud of the partnership we have with the federal government and it is important to us to do the best possible job for the taxpayers and the Medicare beneficiaries. We and our national association hope to be able to continue to work closely with your committee as you consider the resources needed to safeguard the Medicare program and to ensure that Medicare beneficiaries get the quality of services they deserve.

Senator HARKIN. Thank you, Ms. Wood. Thank you all for your fine testimony. I would like to pick up on what you said, Ms. Wood, that caught counsel's attention and mine. Cutting the payment safeguard activity by one-third is like opening the cash drawer and letting people come in and take whatever they want.

I think that pretty well sums it up. I think the people that testified before also talked about the signal that it would send. Now, each of you testified as to the number of auditors that you would probably lose if these cuts were to go into effect. I believe Mr. Horton, you said that you would have to cut 20 field auditors.

Mr. HORTON. Yes, Mr. Chairman.

Senator HARKIN. Mr. Lifson, you said 84, is that field auditors?

Mr. LIFSON. No; that is not field auditors, sir. We are not a part A intermediary. These would be people involved in Medicare program safeguard activities.

Senator HARKIN. Ms. Wood, you said 30?

Ms. WOOD. We have 30 field auditors, yes.

Senator HARKIN. Is that the total number that you would expect that you might have to terminate because of these cuts?

Ms. WOOD. In Iowa our total number is about 144. We have 30 accountants that do field audits. The majority of the remaining positions are in the medical review functions, with fraud and abuse. We have 12 or 13 people in our Medicare secondary payer area.

Senator HARKIN. Because of these cuts, have you thought about how many would have to be cut out of your audits or is 30 the figure that you gave me?

Ms. WOOD. If there were no field audits at all, that would be, the full 30 positions would be reduced.

Senator HARKIN. Let me just say that, if I might, I want to note for the public record that the performance of the Iowa Blue Cross/Blue Shield Medicare contractor dramatically improved over the last year, a perfect score of 100 percent was achieved in several categories with overall performance ratings of 91 percent. I just would like to commend all of you. I can take the time. I am from Iowa, I commend you in doing that. [Laughter.]

I look forward to your continued work to bring about further improvements in this area.

It has been reported to us that each of your organizations reported suspected cases of fraud to the OIG for follow up. We understand between the period of July 1987 and December 1988 Equicor reported 17 cases. South Carolina reported 8 and Iowa reported 76. Why such a discrepancy there? Iowa, you cover how many States? You said you put out about $1.1 billion?

Ms. WOOD. Yes.

Senator HARKIN. You are about the same.

Mr. HORTON. A little higher.

Senator HARKIN. You only reported eight. They reported 76. Equicor, how about you?

Mr. LIFSON. The 17 encompassed just three States. We now have four States. In that year we put out about $700 million.

Senator HARKIN. How come Iowa is so much more?

Ms. WOOD. I think it might be helpful if I mentioned, out of the 76 cases, 11 of those pertained to the part B program of Medicare. That would be comparable to Equicor's experience of 17.

Senator HARKIN. And the rest?

Ms. WOOD. The rest are under the part A portion of Medicare, 65 of those. Now under part A, we are what is referred to as a regional processor for home health agency claims and there are nine of us with that designation nationally. We serve over 1,000 home health agencies that do business in 42 States which means we, in general, have a very high number of audits to do.

We have also been for the past 1½ to 2 years, transitioning those agencies into Blue Cross and Blue Shield of Iowa administration, so we have been doing a very aggressive educational program with those new providers that are just coming on board. I think that has, in the short term, produced a higher volume of cases and, in the long term, it remains to be seen if it will continue at that level.

Senator HARKIN. Mr. Horton, I assume you are not one of the home health agencies?

Mr. HORTON. Mr. Chairman, we are also one of the nine regional home health intermediaries. We serve primarily home health agencies in North Carolina, Kentucky, Tennessee, and South Carolina under that contract.

Senator HARKIN. I guess I am wondering why there is such a discrepancy between 8 and 76 or 65, as you say.

Mr. HORTON. Let me comment since I seem to be the low man on the totem pole with eight. In our operation in South Carolina we work very closely, almost on a daily basis, with representatives of Mr. Kusserow's office, the Office of Inspector General that are actually located in the same city as our Medicare operation, Columbia, SC.

During the time period you referred to, July 1987 through December 1988, we, in fact, investigated nearly 200 potential fraud and abuse situations and most of those were investigated by our internal staff and contacts were made via telephone with the on-site staff from the Inspector General's Office. The resulting eight referrals that were made were those that, in fact, the OIG felt they could pursue and would be able to obtain sanctions against the providers, so the numbers may be a little bit misleading in our case in that we do have ongoing contact with the OIG in the early stages of the investigations.

Senator HARKIN. Is that different than Iowa or Equicor?

Mr. LIFSON. No; it is not, sir.

Senator HARKIN. You do the same thing?

Mr. LIFSON. We had about 1,200 investigations in the period for which you have a report, of which 17 were formally referred to the OIG, but most of those were, in fact, discussed with them prior to that.

One of the great frustrations is developing material, these are very dedicated people who have worked very hard at learning their skills in this area and they dig in and they develop cases and they refer them and it is only their perseverance in following up with both the inspector general and with the FBI that they even know what the status of those cases actually are.

For the Inspector General's Office, I understand they get cases from different areas with different amounts and if you have a case that is only $100,000 and they are pursuing a $2 million case, they tend to put more energies into the $2 million case. That sometimes

discourages people from being as aggressive as maybe they should be.

Senator HARKIN. How many cases in Iowa?

Ms. WOOD. Over 2,000 individual cases went into producing the referrals that we made. I think a footnote here is important to refer back to what the inspector general's testimony had, and that is one of counting, on the part B side, our 11 referrals were from 11 different physicians or providers of care. On the part A side our 65 referrals applied to 25 different providers of care. So it is just a matter of getting some consistency in those numbers, but as you can see it is still a high number either way.

Senator HARKIN. And how many cases total did you investigate?

Mr. HORTON. Two hundred. That would have involved many more individual claims. There were 200 cases. Each case, as Ms. Wood just mentioned, would involve often multiple claims for payment from Medicare.

Senator HARKIN. I am still concerned about the different levels. I think we ought to take a look at all of the different contractors and see what levels of cases were referred. Although I must say that one of the cases you referred to, Mr. Horton, caught my attention, when a hospital sought program reimbursement for the costs of depreciation, interest, salary, and maintenance of operating a private health club on two floors of the hospital building.

Who used the health club? This was not for patients?

Mr. HORTON. It was used by patients in physical therapy at the hospital but primarily it was used by anyone who wanted to pay the membership fee to join the health club.

Senator HARKIN. You say you saved about $370,000 in a 3-year period.

Mr. HORTON. Yes, Mr. Chairman.

Senator HARKIN. On that one, the OIG told us only 6 percent of the cases that you referred to him, you heard him, only 6 percent actually resulted in any kind of a conviction and that most of his initial leads come from sources other than contractors. So I guess my question is how can the number and quality of leads referred by the contractors be increased, both the quality and the number? You are saying most of them come from outside?

Here is a case here, the chair. Congressman Horton on the House side is the one who started that. You are talking about a lot of money for these nice easy chairs but no contractor stepped forward to question it.

Mr. LIFSON. Mr. Chairman, I think one of the members of my committee would take exception to that. That is, the Nationwide Insurance Co., which, in fact, has suffered greatly for aggressively pursuing seat lift chairs. I mean, the chairman of the board's home was picketed by DME—durable medical equipment—suppliers.

Senator HARKIN. Who was this, tell me.

Mr. LIFSON. This is the Nationwide Insurance Co., Medicare contractor in Ohio and West Virginia. There was a firm, whose name I do not know, in the Cincinnati area, which they cover, who aggressively markets seat lift chairs. They have taken a very strong stand with regard to medical necessity of those submissions and the individuals supplying the chairs have taken exception, strong exception to their denials and have gone as far as to picket the homes of the

chairman or the president of the company and the individual who administers the Medicare program for Nationwide Insurance Co.

Senator HARKIN. I can get more information about that. Well, again, we are still stuck at 6 percent. How can we get better? Any suggestions or do we just keep going the way we are?

Mr. HORTON. Mr. Chairman, I believe the recommendations made by Mr. Kusserow earlier would be appropriate if, in fact, there is a desire to significantly increase the number of referrals, the quality of those referrals to the OIG, a greater weight on that function in the evaluation program that the contractors are subject to would certainly result in more resources being allocated there.

I would suggest to you that the record clearly shows that all Medicare contractors, in fact, do refer cases and over the past several years most Medicare contractors have rated very highly on HCFA's annual report card of Medicare contractors. We have not received the feedback, speaking for Blue Cross and Blue Shield of South Carolina only, we have not received the feedback that has come out of this hearing today, that there has been any dissatisfaction on the part of the Office of Inspector General with either the number or the quality of our referrals.

Senator HARKIN. So there has been no feedback from the OIG's office saying; wait a minute, these are not good cases you are handing to me?

Mr. HORTON. Not in our specific instance. I cannot speak for other contractors. We have, in fact, been assured on more than one occasion that the quality of our referrals were in fact good and have not had the issue raised of insufficient quantity.

MORE ON SANCTIONS

Senator HARKIN. What you are saying is the OIG's office has not been coming back to you and saying you are not giving us good cases, let us get better cases, we are not getting good convictions on these. I do not know what your response is, but I suppose their response would be perhaps that there were no penalties that accrue anyway, so as you say, it is a traffic ticket or you kick them out of the program.

Do you think that that might be something that we might want to consider, is to have some other sanctions against those that file these kind of private claims. Mr. Lifson, I see you nodding your head.

Mr. LIFSON. I think so. I think you need a gradation of sanctions and penalties. I think part of the problem might be that the alternatives that are available to people from the OIG's office and so on are more limited than maybe they should be. As I understand it, they are really forced to only pursue cases that will produce suspensions or things like that, the harsher penalties.

Senator HARKIN. Those are always the toughest.

Mr. LIFSON. Correct.

Senator HARKIN. Do you all feel there ought to be some kind of gradation of different penalties and sanctions? How about you?

Ms. WOOD. I think that the inspector general does have discretion to decide what to do as far as sanctions go. It does take a lot of time. It is very expensive to develop these cases, so there is, I

think, a focus on doing those with a potential of high return, make that investment worthwhile.

I think there is also a lot that can be done from a contractor point of view. Instead of talking about penalties or sanctions on contractors, talk about some incentives, and I think contractors respond very well when there is some recognition given, also of who is doing a good job and who are the models and how can that be shared. Those kinds of activities take time and interest on the parties in order to develop those. People who care about it find out on their own how to do a good job, but I think those areas are always important to keep that strong and encourage that relationship.

Senator HARKIN. What kind of incentives do you envision?

Ms. WOOD. Some of the things that are important is simply recognition and support. The media attention given to a contractor's activities, part of the end result of a fraud and abuse program really is the publicity. It is important for the public to know that someone is watching out for their interests, for the taxpayer to know that. It is also important for providers to know that we are checking and doing that part of our job and when that comes out it can be a mixed blessing for a contractor because they are unpopular stands to some degree. So having that kind of recognition that that is a responsibility of all contractors is important.

In addition, as you mentioned, in the way that contractors are evaluated by HCFA for overall performance, the payment safeguards area, fraud and abuse, is a proportionally small piece of that overall and so a contractor is making decisions day in and day out about where to spend the resources and are we doing administratively all of those things that we are responsible for. So we really do not have the luxury to focus in a tremendous amount of depth without showing a return on that. That simply is good business to focus where we can get the best return for the beneficiaries and the investment.

DIFFICULTY IN REESTABLISHING AUDIT ACTIVITIES

Senator HARKIN. The committee was told that the proposed cut of $134 million for payment safeguard activities will result in the elimination of 1,000 positions among the various contractors around the country. The biggest cut proposed by the administration is in the audit activity. What kind of a person with what sort of skills would you be forced to lay off in this activity and how difficult would it be to bring them back on once you have lost them? One of you mentioned something about that. I forget which one it was.

Ms. WOOD. In the audit area, for the field audits, we hire people with accounting degree backgrounds.

Senator HARKIN. Just out of school?

Ms. WOOD. Just out of school. These are generally entry level professional positions. People are interested in building their careers, learning how the business works. It takes us 2 years to fully train an auditor to where, at the end of the 2-year period, he or she is fully capable of auditing the most complex of providers. So the auditors that we are hiring this year in 1989 really are basically the basis of our audit strengths for 1991.

Senator HARKIN. Who would you be losing, would you be losing these people or more experienced people who say they can go on and do something?

Ms. WOOD. Our more experienced people. They have the best marketing skills.

Mr. LIFSON. I believe in fiscal year 1982, it took a very long time for all of the contractors to rebuild their staffs in this area both in the audit area as well as in the medical review and other program safeguard areas.

Mr. HORTON. I would echo Ms. Wood's and Mr. Lifson's comments, Mr. Chairman and reiterate a statement that I made in my oral testimony that most of these auditors will, in fact, go to the other side of the fence, if you will, and they would be engaged in activities that are designed to increase the payout of the Medicare trust funds to the individual providers of care so there really is a double hit. We would not expect to be able to replace these auditors in 1991, if funding was restored, with anywhere near the experience level of the individuals that we would lose. We think that when you lose these people you really lose 2 to 3 years worth of savings when you lose an experienced auditor because it takes that long to hire and train a new auditor.

Senator HARKIN. I understand that some health care consultants, some of you talked about consultants in your testimony, are sponsoring seminars which are advertised with language like "Find creative ways to maximize your Medicare reimbursement dollar," "Make sure you are getting every reimbursement dollar you are entitled to." To what extent are such paid consultants active in your respective areas or States?

Mr. HORTON. I will start, Mr. Chairman. We do have a number of those consultants active in South Carolina. Most of them are active in many States and just happen to provide services in South Carolina.

Senator HARKIN. Same Iowa, same Equicor.

Ms. WOOD. Yes.

Senator HARKIN. So I assume that if you have got to reduce your audit staff, some of them would be highly employable in such consulting operations?

Mr. HORTON. Precisely. Many, in fact, who are now in that business began their careers with Medicare contractors.

Senator HARKIN. Here is the November 1988 issue of the Journal of Health Care Financial Management. There are 20 pages of ads just in one publication. Here is TRIM, "Stop losing charges and money, generates additional cash for the hospital, results in 'clean and complete' patient bills," whatever that may mean. All of this, 20 pages in just one journal.

Here is one here "With increasing financial pressures on hospitals it is imperative you get reimbursed every dollar that you are entitled to from every payor" and on and on, 20 pages in just one, so that is sort of what you were talking about, right, in terms of the consultants out there?

Mr. HORTON. Exactly, Mr. Chairman. That is an excellent illustration of what we face every day in attempting to counter the activities of these consultants that are on the other side of the fence.

Senator HARKIN. Well, again, it just seems to me that this is one place where we are being penny wise and pound foolish. There is just no doubt in your minds, I assume, no doubt in any of your minds, that if we do not fund this, the taxpayers will lose money and that the elderly will have to pay higher premium costs sometime in the near future, is that a fair statement?

Ms. WOOD. Yes.

Mr. HORTON. Absolutely.

Mr. LIFSON. Yes.

Senator HARKIN. For the life of me, I cannot understand how we are doing this, in fact, if anything, because of the dollar returns that we have been able to see. You mentioned 8 to 1 overall nationally, and again looking at the kind of ads that we are getting and the fact that we are embarking on a whole new area now in catastrophic care, covering drugs, covering intermediate care facilities. You have a whole new area out there that we have to audit, and now to take away 1,000 auditors around the United States just opens, as you have said, opens the cash drawer, come and get it and it will make these Medicare costs balloon like we have never seen before.

Again, in my opening statement when I opened this hearing, we have got to tighten down, we have got to make sure that every dollar is used wisely and we still have not reached the point of diminishing returns yet. It is obvious if you get an 8 to 1 return you still have not reached that point of diminishing returns yet.

Thank you all very much for your testimony. I appreciate it. Any last things you wanted to say for the record. Thank you all very much.

STATEMENT OF TERRY COLEMAN, ACTING ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION

ACCOMPANIED BY BARBARA GAGEL, DIRECTOR, BUREAU OF HEALTH CARE OPERATIONS, HEALTH CARE FINANCING ADMINISTRATION

Senator HARKIN. Our last witness will be Terry Coleman, Acting Administrator of the Health Care Financing Administration. Mr. Coleman, welcome to the subcommittee. I wrote a letter to Dr. Roper. Where is Dr. Roper now?

Mr. COLEMAN. Dr. Roper has moved to the White House where he is the head of the Medical Policy Operations.

Senator HARKIN. Mr. Coleman, again welcome, thank you for your prepared testimony which I have had a chance to look over and for being here. I am sure you have heard the different testimonies that we have had this morning and what we are about here with this hearing. Your statement will be made a part of the record. Again, please proceed and sum up in 10 minutes.

Mr. COLEMAN. Thank you, Mr. Chairman. Accompanying me here this morning is Barbara Gagel, Director of HCFA's Bureau of Program Operations.

I am pleased to be here today to discuss the payment safeguard activities of the fiscal intermediaries and carriers who assist the Health Care Financing Administration in administering the Medicare Program. Between 1980 and 1989 total Medicare spending will increase by more than 180 percent, more than 2½ times the rate of growth of overall domestic spending. For the years 1990 through

1994 total outlays are predicted to increase again by more than 50 percent.

We have a chart, you might see over here, showing the tremendous growth in Medicare expenditures, the top line showing the projected growth, the line underneath that showing the growth with the proposed budget cuts, proposed by the President and that bottom line showing the rate of consumer price index inflation. You can see the growth in Medicare expenditures is much more rapid than the expected growth and rate of inflation on this chart.

Senator HARKIN. What is that other chart? I do not understand the other chart. We will get to that pretty soon.

Mr. COLEMAN. I will mention that in just a moment. On the front lines of the Medicare Program, coping with the emerging numbers of beneficiaries in the claims and the growth in Medicare expenditures, as well as the implementation of the extensive annual legislative changes enacted by Congress are the Medicare contractors.

HCFA currently negotiates 88 contracts with private organizations, for the most part insurance companies, who create and process claims for Medicare benefits and carry out certain related functions. This second chart shows the workload increase of our Medicare contractors, the top line, green line, showing the rapid growth in their workload, the bottom line, red line, shows the unit cost of their work going down in recent years.

The key function of Medicare contractors is assuring that the claims they pay are eligible for payment under applicable law and regulations and that proper documentation has been provided. The claims reviews consider coverage of service, eligibility of the beneficiary, screens for duplicate claims and other screens. In fiscal year 1988 contractors denied in whole or in part 54.1 million claims and thus reduced payments by $6.3 billion.

In addition, contractors carry out payment safeguard activities that fall into three broad categories, medical and utilization review, provider audit, and Medicare secondary payer review. Medical review by the contractors gives assurances that medical care provided is covered under Medicare and is both necessary and appropriate.

Utilization review identifies primarily through computer screening techniques utilization patterns that deviate from medically acceptable norms and which may represent fraud and abuse. In fiscal year 1988 contractors performed medical and utilization reviews on 88 million claims or about 20 percent of the claims processed. The return on these reviews in part A averaged 4 to 1. In other words, for every $1 spent, $4 was saved. Part B, the average was 10 to 1.

Provider audit is the primary instrument for maintaining the integrity of program payments to institutional providers. Each year over 24,000 hospitals, skilled nursing facilities, home health agencies, and other providers submit a Medicare cost report. Cost reports represent the provider's claims for about $60 billion in benefit payments.

As part of the audit process the contractor reviews each cost report for accuracy and completeness and identifies data which may be inconsistent with program rules and regulations. In those instances where there are significant discrepancies or where a provider is selected for audit based on other priorities, the auditor ex-

amines the provider's actual accounting records and identifies whether improper payments were made. Fiscal year 1988 contractors audited 8,200 providers or about one-third of all providers. The return on these audits had an average of 7 to 1 in savings achieved.

Finally, contractors identify situations in which other payers are primary responsible in the payment of claims. This is essentially the same concept known in the private insurance industry as coordination of benefits. In 1988 contractors determined that 5.4 million claims were subject to Medicare secondary payer conditions. Returns on part A of this activity averaged 36 to 1. In part B, returns averaged 11 to 1.

The Health Care Financing Administration is convinced that its investments in payment safeguard activities have contributed substantially to program integrity as well as reducing benefit outlays from the Medicare trust fund. Contractors saved about $3.2 billion in fiscal year 1988 from these activities.

Our experience indicates that for every administrative dollar spent on review, audit and MSP, many benefit dollars are saved. For example, in fiscal year 1988 we saved $866 million through medical and utilization review, $909 million to provider audit, and $1.4 billion through Medicare secondary payer activities, a return of more than 7 to 1 on our investment in the first two instances and a return of 22 to 1 on Medicare secondary payer.

I would like to comment on the status of funding for the Medicare contractors. As you know the Reagan administration's fiscal year 1990 budget requests included $1.439 billion for the Medicare contractor activity plus a $100 million contingency. We had originally requested $1.84 billion but this was reduced during budget negotiations with OMB.

While the final level of funding would be only slightly higher than the amount appropriated by the Congress in fiscal year 1989, even though claims volume and other duties are much higher, other demands are much higher, the Reagan budget assumed that through prudent management and continued improvements in productivity, the contractors could accomplish their expanded mission within this budget.

The budget required hard choices. In developing the budget, we felt that given the limited funds available for program administration, emphasis had to be placed on the claims processing function and a reduction absorbed in the funds available for payment safeguard review and audit activities. Our first priority must be to meet the requirements of the law with respect to timely claims payment.

Now, as you know, Mr. Chairman, President Bush has identified priorities for fiscal year 1990, about which we expect to be firm. But the residual freeze area in President Bush's budget, which includes HCFA program management budget are intentionally flexible.

Therefore, it is our clear expectation that in this residual freeze category there will be many cases where an alternative funding mix will be judged desirable and/or necessary.

At HCFA we are very much aware of the budget context in which we find ourselves and we have not been passive in response to downward pressures on the contractor budget. The fiscal year

1990 Reagan budget submission assumed a number of legislative proposals aimed at streamlining contractor operations.

In addition, such administrative initiatives as the common working file, experimentation with fixed price contracts and standard systems development have helped conserve administrative resources. This effort to improve contractor productivity is reflected in a steady decline in unit costs per claim processed at the same time the number of claims has risen sharply. That is again shown on the second chart up there.

We are proud of our partnership with the Medicare contractors. We are particularly pleased with their capacity and willingness to adapt an ever fluid set of programs and administrative requirements.

PREPARED STATEMENT

Mr. Chairman, that concludes the summary of my prepared remarks which I submit to you in full. I will be happy to respond at this time to any questions you may have.

[The statement of follows:]

STATEMENT OF TERRY COLEMAN

Mr. Chairman and Members of the Subcommittee, I am pleased to be here today to discuss the payment safeguard activities of the fiscal intermediaries and carriers who assist the Health Care Financing Administration in administering the Medicare program. The work of Medicare contractors is a critical element in the administration of the Medicare program.

The challenges faced by these Medicare contractors have grown enormously as the Medicare program has expanded in size and scope during recent years. A major portion of the burden of increasing benefit expenditures, claims volume, and program complexity has been shouldered by the contractors.

Program Growth

Between 1980 and 1989 total Medicare spending will increase more than 180 percent, more than two and one-half times the rate of growth in overall domestic spending. And, for the years 1990 through 1994, total outlays are projected to increase again by more than 50 percent. To give you a sense of the tremendous growth the Medicare program is experiencing, I would note that we expect that between 2005 and 2010, total Medicare spending will exceed spending for Social Security cash benefits, making Medicare the nation's largest entitlement program.

HCFA's budget request now pending before this committee projects a 14 percent rise in benefit payments in FY 1990 under current law, with expenditures for benefits in that year reaching $109.2 billion and total Medicare expenditures of almost $112 billion. The number of elderly and disabled individuals enrolled in the program is expected to grow by 652,000, reaching more than 33 million in FY 1990. Part A and B claims volume will increase by about 14 percent to reach 558 million in FY 1990.

Not only are the numbers growing, but the pace of Medicare legislation has been staggering. In little more than 2 years, 4 major bills affecting Medicare have been enacted in rapid succession, including 3 reconciliation bills and most recently, thc Medicare Catastrophic Coverage Act of 1988. Legislation has required that claims payment timeliness standards be met--standards that impose not only a ceiling on claims processing times, but also a floor or minimum time for processing. In addition, claims from participating physicians are subject to different timeliness rules and their payment amounts are subject to the full Medicare Economic Index update while payments to other physicians are not. The catastrophic bill will require many changes in the way Medicare claims are processed, and none more imposing than the need to establish a wholly new payment system for prescription drug claims.

Role of the Contractors

On the front lines of the Medicare program, coping with the burgeoning numbers of beneficiaries and claims, as well as the rapid pace of legislative change, are the Medicare contractors. HCFA currently negotiates 88 contracts with private organizations, for the most part insurance companies, who agree to process claims for Medicare benefits and carry out certain related functions. In the Hospital Insurance program, or Part A of Medicare, the intermediaries determine the amount of benefits payable to hospitals, skilled nursing facilities, hospices, and home health agencies; make payment to these facilities out of funds advanced by HCFA; assist facilities to establish and maintain accurate financial records; and furnish program information to providers and beneficiaries. In Part B, or Supplementary Medical Insurance, carriers play a similar role with respect to claims for payment for physician services and certain other medical services, supplies, and equipment.

The cost of processing claims varies across the contractor

community. In Part A the high unit cost is $3.17, the low is $1.49 and the average is $2.05. In Part B the high is $2.42, the low is $1.33 and the average is $1.57.

A key function of the Medicare contractors is assuring that the claims they pay are eligible for payment under applicable law and regulations and that proper documentation has been provided. Claims reviews consider coverage of service, eligibility of the beneficiary, screens for duplicate claims and other screens. In FY 1988, contractors denied in whole or in part 54.1 million claims and thus reduced payments by $6.3 billion.

Payment Safeguard Activities

In addition, contractors carry out payment safeguard activities that fall into three broad categories -- medical and utilization review, provider audit, and Medicare secondary payer review. Medical review by the contractors assures that medical care provided is covered under Medicare and is both necessary and appropriate. Utilization review identifies, primarily through computer screening techniques, utilization patterns which deviate from medically accepted norms and which may represent program abuse. Follow-up actions are taken where necessary to prevent a continuation of systematic overutilization. Corrective actions following both types of review include direct educational efforts as well as referral of apparent fraud and abuse cases to the proper authorities for development and possible prosecution. In FY 1988, contractors performed medical and utilization reviews on 88 million claims, or about 20 percent of the claims processed. The return on these reviews in Part A ranged from a high of 25:1 to a low of .4:1 with an average of 4:1. In Part B the high was 27:1, the low was 5:1 and the average was 10:1.

Provider audit is the primary instrument for maintaining the integrity of program payments to institutional providers. Each year, over 24,000 hospitals, skilled nursing facilities, home

health agencies, and other providers submit a Medicare cost report. The cost reports represent the providers' claims for about $60 billion in benefit payments, and provide cost and statistical data needed to respond to legislative and policy issues. As part of the audit process, the contractor reviews each cost report for accuracy and completeness, and identifies data which may be inconsistent with program rules and regulations. In those instances where there are significant discrepancies, or where a provider is selected for audit based on other priorities (e.g., multi-facility hospitals, chain affiliated providers, and high utilization nursing facilities and home health agencies), the auditor examines the providers' actual accounting records to identify whether improper payments were made. In fiscal year 1988 contractors audited 8,200 providers, or about one-third of all providers. The return on these audits ranged from a high of 21:1 to a low of -5:5 with an average of 7:1.

Finally, contractors identify situations in which other payers are legally primary to Medicare in the payment of claims. This is essentially the same concept known in the private insurance industry as coordination of benefits. Until 1980, when Congress began to mandate that Medicare pay only secondary benefits in certain situations, the Medicare program had generally assumed a position of primary payer responsibility. Since 1980, a series of changes in the Medicare law have made Medicare secondary to automobile medical, no fault, or any liability insurance, most employer group health plan (EGHP) coverage for aged beneficiaries who are employed or have coverage through an employed spouse, and some EGHP coverage offered to disabled beneficiaries through employment or a family member's employment.

Contractors review all claims as they are submitted to ascertain whether other health or liability insurance coverage is in

effect. Data exchange among contractors and review of Social Security earnings records are helpful in identifying secondary payer cases. Based on this coverage information, contractors either deny or reduce payment initially, or institute recovery action post-payment. In 1988, contractors determined that 5.4 million claims were subject to Medicare secondary payer provisions. Returns in Part A ranged from a high of 141:1 to a low of 15:1 with an average of 36:1. In Part B returns ranged from a high of 30:1 to a low of 2:1 with an average of 11:1.

The Health Care Financing Administration is convinced that its investments in payment safeguard activities have contributed substantially to program integrity as well as reducing benefit outlays from the Medicare trust funds. Contractors saved about $3.2 billion in FY 1988 from these activities. Our experience indicates that for every administrative dollar spent on review, audit, and MSP, many benefit dollars are saved. For example, in FY 1988 we saved $866 million through medical and utilization review, $909 million through provider audit, and $1.4 billion through Medicare secondary payer activities--a return of more that 7 to 1 on our investment in the first two activities and a return of 21 to 1 on MSP. Payment safeguard savings are real, not just theoretical, and have been documented in independent audits. Copies of these audits have been provided to Committee staff. While this committee has jurisdiction over only the administrative cost side of that equation, it is important to bear in mind the larger picture and the benefit savings that do accrue to the trust funds.

Medicare Contractor Funding

In closing, I would like to comment on the status of funding for the Medicare contractors. The Reagan Administration's FY 1990 budget request included $1,439 million for the Medicare contractor activity, plus a $100 million contingency reserve.

While this level of funding would be only slightly higher than the amount appropriated by the Congress for FY 1989, the Reagan Budget assumed that through prudent management and continued improvements in productivity the contractors could accomplish their expanded mission within this budget. The Reagan budget required hard choices. In developing the Reagan budget, we felt that given the limited funds available for program administration, emphasis had to be placed on the claims processing function per se and a reduction absorbed in the funds available for payment safeguard review and audit activities. Our first priority must be to meet the requirements of the law with respect to timely claims payment.

As you know, President Bush has identified his priorities for FY 1990 -- about which we expect to be firm. But in the residual freeze area, our intention is to be flexible. Therefore, it is our clear expectation that in the residual freeze category there will be many cases where an alternative funding mix will be judged desirable and/or necessary.

The Department's original FY 1990 budget request to OMB included $1,840 million for the Medicare contractors, a 35 percent increase over the 1989 program level. Subsequent budget negotiations reduced this original request to the $1,439 million included in the Reagan budget -- a 6 percent increase over FY 1989 -- with HCFA distributing funds between contractor activities. (See attached chart.)

At HCFA we are very much aware of the budget context in which we find ourselves and we have not been passive in response to downward pressures on the contractor budget. The FY 1990 Reagan budget submission assumed a number of legislative proposals aimed at streamlining contractor operations. In addition, such administrative initiatives as the common working file, experimentation with fixed price contracts, and standard systems

development have helped conserve administrative resources. This effort to improve contractor productivity is reflected in a steady decline in unit costs per claim processed at the same time that the number of claims has risen sharply. We are proud of our partnership with the Medicare contractors and are particularly pleased with their capacity and willingness to adapt to an ever fluid set of program and administrative requirements.

This concludes my prepared remarks and I would be happy to respond at this time to any questions you may have.

MEDICARE CONTRACTOR BUDGET
FY 1990
(Dollars in Millions)

	FY 1989 APPROP	FY 1990 DEPT REQUEST	FY 1990 BUDGET	CHANGE 90 BUDGET FROM REQUEST	CHANGE 90 BUDGET FROM 89 APPROP
PAYMENT SAFEGUARDS					
Med Review/Util Review	$162.0	$228.9	$114.6	($114.3)	($47.4)
Audit	133.0	153.3	66.7	(86.6)	(66.3)
Medicare Secondary Payer	68.1	78.3	48.0	(30.3)	(20.1)
TOTAL - Payment Safeguards	363.1	460.5	229.3	(231.2)	(133.8)
PRODUCTIVITY INVESTMENTS	40.5	84.4	57.2	(27.2)	16.7
CLAIMS PROCESSING					
Bills/Claims Payment	657.4	743.2	669.8	(73.4)	12.4
Reimbursement	34.2	38.1	35.5	(2.6)	1.3
Printing	2.5	5.3	5.3	0.0	2.8
Fixed Price Contracts	35.2	83.5	83.5	0.0	48.3
TOTAL - Claims Processing	729.3	870.1	794.1	(76.0)	64.8
BENEFICIARY/PROVIDER SRVCS					
Hearings	69.1	92.7	53.4	(39.3)	(15.7)
Bene Communications	91.2	120.8	115.0	(5.8)	23.8
Professional Relations	8.8	21.2	7.3	(13.9)	(1.5)
TOTAL - Bene/Prov Services	169.1	234.7	175.7	(59.0)	6.6
PARTICIPATING PHYSICIANS	29.6	32.3	24.7	(7.6)	(4.9)
DRUGS	30.0	158.0	158.0	0.0	128.0
TOTAL OPERATING BUDGET	1361.6	1840.0	1439.0	(401.0)	77.4
CONTINGENCY	98.8	75.0	100.0	25.0	1.2
TOTAL CONTRACTOR BUDGET	$1,460.4	$1,915.0	$1,539.0	($376.0)	$78.6

AUDITS OF SAVINGS

Senator HARKIN. Thank you. I understand that 2 years ago HCFA contracted with several major CPA firms to audit the savings as reported by the contractor. Could you described the results of those reviews for the committee and do you believe that those reviews certify the savings reported to you by the contractors?

Mr. COLEMAN. That is correct, Mr. Chairman. In July 1986 we did contract with several CPA firms to audit the reported payment safeguard activities of 10 of the largest Medicare contractors. These firms began with the reports the contractors submitted showing payment safeguard activities. They tracked those savings back to the accounting ledgers, to be certain that savings were reported correctly and they also took a sample of ledger entries and tracked back the original claims to ensure that what was in the ledger was accurate.

The CPA firms reported to us that they found contractor reports of savings were about 98.9 percent accurate. In other words, they confirmed, they validated that about $10 was saved for every $1 spent in payment safeguard activities.

Senator HARKIN. About 10 to 1?

Mr. COLEMAN. Yes; under that study.

Senator HARKIN. So it did certify the savings reported by the contractor. Mr. Coleman, as you know, you were here when we were talking before about the 1,000 point performance rating system.

Mr. COLEMAN. Yes, sir.

Senator HARKIN. The contractors assign 305 points for the payment safeguard activities for part A contractors and 205 points for these activities for part B contractors. In addition, about 70 points go for fraud and abuse activities.

Do you feel that adequate weighting is given to these important activities which as everyone seems to agree saves us money, obviously 10 to 1?

Mr. COLEMAN. The problem is that the contractor performs many important activities in addition to this particular activity. The most important thing that they do is to process the claims correctly. They pay the beneficiaries and they pay the providers. That is a very important activity. It is done under standards of timeliness and accuracy required by law and that must be given a great deal of weight. Another important activity that they undertake is to deal with beneficiaries and providers who have complaints and problems. That is another thing that is very important.

On the whole, we think this is an adequate assessment of the importance of payment safeguard activities. It is, I agree with you completely, it is very important but they do so many important things that we cannot rate this so highly that it overshadows the other very important activities that they perform.

Senator HARKIN. I agree that it is an important activity to make sure Medicare claims are processed expeditiously, and that we maintain high-quality services to providers and beneficiaries. Yet, when you have a program this large, spending more than $100 billion annually, there is a responsibility to safeguard the taxpayer's money. Would you agree with previous testifiers who said these are

hard savings, these are actual dollars saved, not some phoney kind of OMB or contrived budget savings? [Laughter.]

HARD SAVINGS

Mr. COLEMAN. Some of them are certainly hard savings, savings in the audit function is a hard savings. The savings from the Medicare secondary payer is a hard function. I think there is some internal debate as to the extent to which savings from the medical review function is a hard function, hard savings, because when, for example, if you deny a claim because the documentation is incomplete, it might be that the documentation would be made complete and so no savings would result, but there certainly are savings there that we are foregoing.

Senator HARKIN. Certainly on the audit, Medicare secondary payment, and fraud and abuse, those are all hard savings.

Mr. COLEMAN. Absolutely.

Senator HARKIN. And medical review, some yes, some no.

Mr. COLEMAN. That is correct.

Senator HARKIN. Do we have any idea about that?

Mr. COLEMAN. I do not think we have a way of estimating that.

Senator HARKIN. That would be pretty hard, but it is hard savings. Again, it just seems to me that with the expansion program that we are going to have this year with catastrophic care, as I mentioned, the aspects of drug and intermediate care, and then reducing the audits at that time, now, is this taken into account during your deliberations? HCFA submitted a request to OMB for $1.8 billion, is that right?

Mr. COLEMAN. That is correct.

Senator HARKIN. You said through subsequent negotiations that came down to $1.4 billion.

Mr. COLEMAN. Correct.

Senator HARKIN. Well, was the new catastrophic care program taken into account in these deliberations?

Mr. COLEMAN. It was taken into account, and that is why we asked for the $1.8 billion. The decisions were very hard decisions. We were competing against other activities in the department like AIDS research and so forth. These were hard choices and we are not completely happy with the outcome but given the restrictions on the budget that we faced, it was the best available settlement we could achieve.

Senator HARKIN. Well, then, do you support these budget cuts?

Mr. COLEMAN. I support the—remember, the Reagan budget submitted a precise number. We support that cut under the circumstances. It is not what we desired. We could certainly use additional money. We support it under the circumstances. The Bush budget now has this provision in the portion of the budget which is subject to negotiation. It is in the portion of the budget where some activities can go up in amounts and some can go down. I think this is a prime activity where additional funds could be justified as part of the flexible freeze concept.

Senator HARKIN. Let me read back to you from your testimony at page 8:

But in the residual freeze area our intention is to be flexible. Therefore, it is our clear expectation that in the residual freeze category, there will be many cases where an alternative funding mix will be judged desirable and/or necessary.

I do not understand that. What does that mean?

Mr. COLEMAN. As you know, the Director of OMB, Mr. Darman, is engaged in a series of discussions with Congress——

Senator HARKIN. In fact, I am supposed to be over there right now.

Mr. COLEMAN [continuing]. About what to do with this category in which he wants to be flexible. He regards that category as being subject to negotiations with Congress.

Senator HARKIN. This category we are talking about right now.

Mr. COLEMAN. This is in the category, the program management budget including the payment safeguards budget is in the category that Mr. Darman is negotiating with Congress about. It is one of those categories where as a result of the negotiations some activities will go up and some will go down. As I suggested to you earlier, I feel this seems to me a good case to be made, this is one of the activities where the budget ought to go up from what was in President Reagan's budget.

Senator HARKIN. Well, I do not want to get into this with you, I do not think. But in terms of scoring OMB, budget scoring and stuff like that, we will be talking about that, too, in terms of the savings that would accrue from this, but we will be talking to the Budget Committee about that.

Again, Mr. Coleman, the committee has seen the overall 1988 evaluations of contractors. The average score for part A contractors was a rating of 93 percent. The lowest score for part B contractors was 90 percent. Do you feel your evaluation system is rigorous enough if everyone is able to score above 90 percent.

Mr. COLEMAN. This is the first year that has happened, Mr. Chairman. I think Ms. Gagle can add to this but we think that the contractors have made great improvement recently. You mentioned Iowa Blue Shield, for example, one contractor who has made significant improvement. We have pressed them very hard. In light of the efforts we have made in recent years to improve their performance, that they now for the first time are at that high level does not particularly surprise us.

STATEMENT OF BARBARA GAGEL

Ms. GAGEL. We certainly expect all of the contractors to meet our standards, indeed, and hold them to that. We are, quite frankly, very pleased with the scores that we received in the 1988 CPEP evaluations. I think they do demonstrate overall good performance in the contractor community. Our evaluation program is one measure of that.

Other measures of it are the results that you see displayed in terms of payment safeguard savings, timeliness in which we pay bills, the extent to which providers or beneficiaries are complaining about the level of service that we get from the contractors.

Quite frankly for 1988, most of that was at a minimum and we essentially had a good year and are very pleased that the contractors met the standard. We hold them to those standards. We award

them bonus points when they exceed our standards and that is, in fact, why we have such a high range in the scores this year because the contractors made very much of a point of exceeding the standards where ever they could, so they could win bonus points, if you will, and increase their relative performance relative to other contractors.

Senator HARKIN. I asked both GAO and OIG what they would do to improve the contractor's effectiveness, so that they are more efficient in achieving savings through payment safeguard activities.

Again, I want to ask you about the problem we have when someone says it is either a slap on the wrist or a nuclear bomb. There are no in-between sanctions. I am really concerned about the lack of any sanctions that are available for providers who file false claims or who have a pattern of filing erroneous claims. You can always deal with one or two erroneous claims, but if there is a definite pattern, we do not have any sanctions for it. Have you recommended any sanctions or any change in this or do you have a basket of sanctions we can draw from?

Mr. COLEMAN. There are other sanctions. I think there was some confusion in the testimony between alternative sanctions against providers and alternative sanctions against the contractors. When Mr. Kusserow said something about a traffic ticket and a nuclear bomb, I think he was referring to sanctions against the contractors. In fact he does have alternative sanctions for providers. He has a range of civil money penalties, fines, that he can impose on people, physicians, hospitals, whoever submits false claims. On the issue of contractors——

Senator HARKIN. How often does that happen?

Mr. COLEMAN. I cannot give you numbers. He has dozens of those in the works at various stages.

Senator HARKIN. How does that, when he levies a fine, is this a nonjudicial type of proceeding, administrative proceeding.

Mr. COLEMAN. They have a hearing before the administrative law judge if they want to contest it and then to the courts.

Senator HARKIN. I would like to get more information about the level of fines, and what the OIG is doing. He was talking about the contractors, not the providers. Why do not those same sanctions apply to contractors?

Mr. COLEMAN. Contractors are a much more difficult problem. One of the main problems, when it goes to the structure of the operation, we by and large have cost reimbursement contracts with the contractors. In other words, they do not have the opportunity to make a profit or a loss, we just reimburse their costs. Of course, if we were to propose some sort of fine on them so they got themselves into a money-losing situation they might be quite reluctant to continue in a contractual relationship with us.

One of the recommendations that we have argued is that we ought to have greater authority to enter into fixed price contracts with contractors so that they have an opportunity to earn a profit, have large incentives, by the same token then we could have loss of profit and disincentives, if necessary, for the project.

Ms. GAGEL. I might add to that, Mr. Chairman, that we have had the authority on an experimental basis to enter into fixed price contracts with contractors and those contracts usually include the

performance incentives of one kind or another so the better job a contractor did, he received a financial reward, if you will, for doing that.

Those experiments have been going on now for about 5 years and have been evaluated as being generally very effective in terms of improving contractor operations.

Senator HARKIN. How many of these fixed price agreements do you have out there now?

Ms. GAGEL. At the moment there are only three active? Over the last 5 years there have probably been up to 10 such contracts. Many of them included not only financial incentives for doing a good job but financial penalties for inadequate work. The GAO has evaluated several of those contracts, as has HCFA. We are about to evaluate the ones that will end this year. It is a very valuable technique for us.

Senator HARKIN. Again, I will have to look at that, too. Tell me, what do you, if we are not going to restore these cuts, you said something about increasing productivity to make up for it. What steps do you recommend for the contractors that they should take if, in fact—now, do you agree that they will have to let go auditors?

Mr. COLEMAN. Yes; we estimate something like a total loss of 2,600 jobs in that vicinity across the country.

Senator HARKIN. We were told 1,000.

Mr. COLEMAN. That is more than just auditors. That is the entire work force effected.

Senator HARKIN. How do you make up for that, do you just work more overtime or what?

Mr. COLEMAN. In terms of systems improvements, we are in the process of adopting standard systems for the various contractors which should include their productivity efficiency, we are working on a development of a common working file to link the part A and part B data to give them more information to work from. We are using more sophisticated tools for medical review, such as diagnostic coding and physician practice patterns and those are the kinds of systems that we think, plus we have a major study that we have a consultant undertaking to look at, the various contractors, to determine who is able to operate most efficiently and hope that that study should be available this summer and it will produce some good information about how to improve productivity. It is those kinds of systems that we hope will assist them in improving the productivity.

Senator HARKIN. I will get that from the record and I will ask the contractors about that and see what they can do, but I think the burden is always, if someone says, well, we can cut that many people out and still get the job done just as effectively, the burden is on the job of the person that says that.

Mr. COLEMAN. I do not make the statement that they would do the entire job. We clearly are going to have a loss of savings. Clearly there will be audits that will not be done, there will be medical reviews that will not be done. It will not be the same job that they did before.

Senator HARKIN. I do not know. Maybe I have a mind block or something, but I do not understand cutting something that is going to cost savings, it is going to cut the hard dollars that we actually

get, that it is going to cost us money. This does not make much sense to me. I was brought up differently, I guess. I just do not understand that.

There can be cuts made I think, legitimate cuts that can be made in the budget in areas that do not necessarily affect national security or our national economic well-being, but in those areas in which it can be demonstratively showed that this activity actually gives us what was called hard savings, which you said would also accrue, that it does not make much sense to cut it.

I do not really have any more questions unless you have anything else that you wanted to bring up.

Mr. COLEMAN. No; thank you.

Senator HARKIN. Well, I am about to leave and go. I do not know if Mr. Darman is still over there on the full committee, but I intend to talk to him about this area and I just want to thank all of the witnesses for providing excellent testimony.

It is useful to me as the new chairman of this subcommittee to learn in detail about a very important program. I was shocked to learn that the Reagan/Bush budget proposals cut one part of the Medicare program that actually saves the taxpayers billions of dollars and for every $1 spent saved over $8.

We learned this morning that the Health Care Finance Administration's original request of $460.5 million for payment safeguard activities was cut in half. This reduction of $231 million will cost the taxpayers nearly $2 billion.

Again, to repeat, for emphasis sake, it does not make sense to me to let wasteful spending practices go unchecked. We can sure put these savings to better use in such programs as Head Start, handicapped education, student aid, rural health initiatives, and all of the activities President Bush has spoken about, as well as using the savings to further reduce the deficit.

Additionally, these programs detect fraud and deter criminal activities. So it is not only the hard savings you get, it is the deterrence of further improper activities that results from this payment safeguards program.

I will be writing Senator Sasser and meeting with him to inform him of this situation and to encourage him and members of the Budget Committee to make adequate room in this year's budget resolution to permit us to restore the funding cut from Medicare contractors. As we have learned from today's testimony, this would have the net effect of saving the taxpayers eight times more than it costs.

CONCLUSION OF HEARING

So again thank you all for coming. The subcommittee will now stand in recess until March 9, when we will hear from Secretary Dole on the Department of Labor's budget.

[Whereupon, at 12 p.m., Tuesday, February 28, the hearing was concluded, and the subcommittee was recessed, to reconvene at 10 a.m., Thursday, March 9.]

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